MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (9)

C8141

CERTIFICATE OF DEATH

Reg. Diat. No. 218

1. PLACE OF DEATH:

County: Montgomery

City or town: Gaithersburg
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 2 yrs

Hospital, Institution, or street address where death occurred:
8 Walker Ave

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Montg

City or town: Gaithersburg
(If outside city or town limits, write RURAL and give nearest town)

Street No. 8 Walker Ave
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME: Minnie R Arnold

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
female	white	widowed

6.(b) Name of husband or wife: Harry Arnold

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): April 22 1869

8. AGE: Years 77 | Months 4 | Days 4 | If less than one day ..... hrs. ..... min.

9. Birthplace: Forestville, P.G.Co md
(Town, county, and state)

10. Usual occupation

11. Industry or business

FATHER
12. Name: Wm B. Dorsey
13. Birthplace: Forestville md

MOTHER
14. Maiden name: Mary M. Stonestreet
15. Birthplace: Forestville md

16. Informant: Virginia Wickenmeier
Address: 2301 Mt View Pl. S.E. Wash DC

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Aug 29-46 (month) (day) (year)

Cemetery or crematory: Congressional

Location: Washington D.C.

18. Funeral director: Thomas Murray

Address: Washington, D.C.

19. Aug 26 1946 Alveda G. Coote Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Aug 26 19 46, at 7:40 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Aug 24 19 46, to Aug 26 19 46 and that I last saw h-- alive on Aug 26 19 46

Immediate cause of death	DURATION
Cerebral embolism	2½ days
Due to	
Due to	
Other conditions: endocarditis	1 yr.

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE: Frank J. Bouchat M.D.
M. D. or other

Address: Gaithersburg md Date signed: 8-26-46

VS A15

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (131-6)

CERTIFICATE OF DEATH

C8142

Reg. Dist. No. 216

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County: Montgomery
City or town: Bethesda, (If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, Institution, or street address where death occurred: Suburban Hospital
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)
State: Maryland County: Montgomery
City or town: Bethesda (If outside city or town limits, write RURAL and give nearest town)
Street No. 4315 - East West Highway (If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME: NEIL BAIRD

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

B.(b) Name of ~~husband or~~ wife: Edith B. Baird
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): September 11, 1884

8. AGE:	Years	Months	Days	If less than one day
	61	11	5	hrs. min.

9. Birthplace: LAKE COUNTY, Indiana (Town, county, and state)
10. Usual occupation: General Passenger Agent
11. Industry or business: Northern - Pacific Railroad

FATHER
12. Name: Andrew Baird
13. Birthplace: Balenteer, Ireland

MOTHER
14. Maiden name: Martha Knox
15. Birthplace: Balenteer, Ireland

16. Informant: Mrs. Edith B. Baird
Address: 4315 - East West Hgwy - Bethesda, Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Aug. 19, 1946 (month) (day) (year)
Cemetery or crematory: Des Moines
Location: Des Moines, Iowa

18. Funeral director: Martin W. Hysong Co.
Address: 1300 - N Street N.W. Wash. D.C.

19. 8/16 1946 (Date rec'd by registrar) Mrs E Jobes Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Aug. 16 1946 at 4:05 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from April 26 1946, to Aug. 1946, and that I last saw h. in alive on August 19 1946

Immediate cause of death: Acute Cardiac Failure — DURATION: ?

Due to: Malignant Hypertension — DURATION: ?

Due to:

Other conditions: Chronic Glomerulo Nephritis

(Include pregnancy within 3 months of death)

Major findings of operations:

Autopsy results: Healed Infarct of Heart and Pleural Effusion, Dilated Heart and Hyperemia of Lungs

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: J. A. Martinez, M. D. or other
Address: 4648 - 2nd - West Hgwy Date signed: Aug. 16/46

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (99)

CERTIFICATE OF DEATH

C8143

Reg. Diat. No. 216

1. PLACE OF DEATH:

County: Montgomery

City or town: Bethesda Md.
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? Since Aug. 9

Hospital, Institution, or street address where death occurred:
Suburban Hosp.

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: D.C. County:

City or town: Chevy Chase
(If outside city or town limits, write RURAL and give nearest town)

Street No. 5525 — 39th St.
(If rural, give LOCATION)

2.(a) If veteran, name war:

3. (a) FULL NAME: Isabella Anderson Barr

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, ~~widowed, or divorced~~
F	W	

6.(b) Name of husband or wife: Edwin M. Barr

6.(c) If alive, give age: 74 years

7. Birth date of deceased (mo., day, yr.): June 26, 1871

8. AGE: Years	Months	Days	If less than one day: hrs.	min.
75				

9. Birthplace: Crewe-Cheshire England
(Town, county, and state)

10. Usual occupation: Housewife

11. Industry or business:

FATHER
12. Name: Wm. Morrison
13. Birthplace: Scotland

MOTHER
14. Maiden name: Elizabeth Smith
15. Birthplace: Scotland

16. Informant: Hosp. records
Address:

17. Burial (Burial, cremation, or removal. Which?) Date thereof aug 27-1946 (month) (day) (year)

Cemetery or crematory: Edgar Hill Cemetery

Location: Suitland Maryland

18. Funeral director: Arthur E. Johnson

Address: 2007 Nicholson St SE

19. 8/24 1946 (Date rec'd by registrar) Wm E Jones Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 24 Aug. 1946 at 9:25 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 9 Aug. 1946 to 24 Aug 1946 and that I last saw h.e.r. alive on 23 Aug. 1946

Immediate cause of death	DURATION
Embolism, multiple, pulmonary and to right leg	13 days
Due to Thrombosis right iliac artery	13 days
Due to Acute auricular fibrillation with acute cardiac decompensation	16 days
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: Embolism right femoral artery at profunda branch Date of op. 14 Aug '46

Autopsy results: N.o.n.e.

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide — Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury — Injured at work?

23. SIGNATURE: Stewart Lahaff, M.D. (M. D. or other)

Address: 3921 Ingomar St. NW Date signed 24 Aug '46

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

Evidence for change of mother's name appears on Film G106 8/30/46 DM

BIRTHDATE: Dr.'s letter filmed 9-9-46 G106 LL

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (14)

CERTIFICATE OF DEATH

08144

Reg. Dist. No. 216

1. PLACE OF DEATH:

County Montgomery

City or town Bethesda (Md.)

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? Since 9:10 P.M. 8-24-'46

Hospital, Institution, or street address where death occurred:

Suburban Hosp.

How long in hospital or institution? -16 hrs.

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md. County Montgomery

City or town Bethesda, Md.

(If outside city or town limits, write RURAL and give nearest town)

Street No. 7904 Wisconsin Ave.

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME Mr George Edington Bell

3. (b) Social Security Number 216-09-8892

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	W	

6.(b) Name of husband or wife Katherine Turner Bell

6.(c) If alive, give age ? years

7. Birth date of deceased (mo., day, yr.) June 16, 1888

8. AGE: Years	Months	Days	If less than one day
58	2	9	...hrs. ...min.

9. Birthplace Potomac, Maryland (Town, county, and state)

10. Usual occupation Asst. Co. Bldg. Inspector

11. Industry or business

FATHER 12. Name George R. Bell

13. Birthplace Potomac Md.(?)

MOTHER 14. Maiden name Lavinia ~~Dutley~~ Myers

15. Birthplace Potomac, Md.(?)

16. Informant George E. Bell, Jr.

Address 7904 Wis. Ave. Bethesda

17. Burial (Burial, cremation, or removal. Which?) Date thereof 8/27/46 (month) (day) (year)

Cemetery or crematory Potomac Church Cem.

Location Potomac Md.

18. Funeral director Wm Reuben Plumphrey

Address Bethesda, Md.

19. 8/26/46 (Date rec'd by registrar) Wm E Johns Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug 25 19 46, at 12:50 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sept. Med. Exam 19..., to ...19...

and that I last saw h... alive on Med. Exam card 19...

Immediate cause of death	DURATION
Bullet wound (2) in rt. side of skull	16 hrs.
Due to Suicide	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Suicide Date of 8-24-46

Where did injury occur? Bethesda (City or town) Monty (County) Md (State)

Injured at home, farm, industry, public place (where?) home

Means of injury Revolver shots Injured at work? No

23. SIGNATURE Frank J. Brockhurst M.D. Sept. Med. Exam. M. D. or other

Address Gaithersburg Md. Date signed 8-25-46

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (18)

CERTIFICATE OF DEATH

08145 218

Reg. Dist. No.

1. PLACE OF DEATH:
County Montgomery
City or town Goshen Md
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? Sixty Years
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Montgomery
City or town Goshen Md Rural
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME James W. Bell

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	Col	Married

6.(b) Name of husband or wife Annie E Bell
6.(c) If alive, give age 68 years

7. Birth date of deceased (mo., day, yr.) Nov 15 1874

8. AGE:

Years	Months	Days	If less than one day
71	9	10	...hrs. ...min.

9. Birthplace Washington D C
(Town, county, and state)
10. Usual occupation Farmer
11. Industry or business Farming
FATHER 12. Name John Bell
13. Birthplace Washington D. C.
MOTHER 14. Maiden name Jemima Wilson
15. Birthplace Montgomery Co Md
16. Informant Annie E. Bell
Address Gaithersburg Md
17. Burial (Burial, cremation, or removal. Which?) Date thereof Aug 28 1946 (month) (day) (year)
Cemetery or crematory Brookside Grove Md
Location Montgomery Md
18. Funeral director Roy W. Barber
Address Gaithersburg Md
19. 8/28 1946 L O Bell Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH August 25, 1946, at 5:00 P. M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from November 12, 1945 to August 25 1946.
and that I last saw him alive on December 15 1946.
Immediate cause of death Coronary Occlusion — DURATION 1 Hour
Due to Arteriosclerotic cardiovascular disease. — 10 years
Due to
Other conditions
(Include pregnancy within 3 months of death)
Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE James P. Kerr M.D.
M. D. or other
Address Damascus, Md. Date signed 8/26/46.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS-A15 9-45-15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (46-0) K

CERTIFICATE OF DEATH

B ★ 08146

Reg. Dist. No. 216

1. PLACE OF DEATH:

County: Montgomery

City or town: Bethesda

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, Institution, or street address where death occurred: Suburban Hospital

How long in hospital or institution? 6 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: ... County: ...

City or town: Washington D C

(If outside city or town limits, write RURAL and give nearest town)

Street No. 3547 Dukes St. N.W.

(If rural, give LOCATION)

2.(a) If veteran, name war: ...

3.(a) FULL NAME Mrs - Edna H. Bishop

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	widow

6.(b) Name of husband or wife: Williams

6.(c) If alive, give age ... years

7. Birth date of deceased (mo., day, yr.): Nov. 10, 1880

8. AGE:

Years	Months	Days	If less than one day
65	9	6	... hrs. ... min.

9. Birthplace (Town, county, and state): Cincinnati - Ohio

10. Usual occupation: Housewife

11. Industry or business: ...

FATHER — 12. Name: Edward Herancourt

FATHER — 13. Birthplace: Cincinnati - Ohio

MOTHER — 14. Maiden name: Catherine Merkle

MOTHER — 15. Birthplace: Unknown.

16. Interment: Mrs Jesse E Johnson

Address 3547 Quebec St. NW Wash. D.C.

17. Removal or Burial (Burial, cremation, or removal. Which?) Date thereof Aug - 17 - 1946 (month) (day) (year)

Cemetery or ~~crematory~~: Spring Grove.

Location: Cincinnati - Hamilton Co. Ohio.

18. Funeral director: Hames & Pumphrey -

Address: Silver Spring - Maryland.

19. 8/17 1946 (Date rec'd by registrar) Wm E Jones Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Aug - 16, 1946, at 7 15 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 8-7-46 1946 to 8-16 1946

and that I last saw h... alive on 8-16-46 1946

Immediate cause of death	DURATION
Primary annular carcinoma of rectosigmoid junction	18 Mos
Due to: Extensive Metastasis to Liver	
Due to: Jaundice cachexia.	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ... Date of op. ...

Autopsy results: Same as above.

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ... Date of ...

Where did injury occur? ... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) ...

Means of injury: ... Injured at work?

23. SIGNATURE: Kenneth B Pumphrey MD M. D. or other

Address 8252 Dakota Road Date signed 8-16-46

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (159)

CERTIFICATE OF DEATH

08147

Reg. Diat. No. 223

1. PLACE OF DEATH:

County: Montgomery

City or town: Takoma Park
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:
1102 Greenwood Ave.

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Montgomery

City or town: Takoma Park
(If outside city or town limits, write RURAL and give nearest town)

Street No. 1102 Greenwood Ave.
(If rural, give LOCATION)

2.(a) If veteran, name war: no

3.(a) FULL NAME: ANNE MARIE BROWNING

3.(b) Social Security Number: none

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
female	white	single

6.(b) Name of husband or wife: X

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Aug. 5th. 1946

8. AGE: Years	Months	Days	If less than one day
X	X	X	X hrs. 10 min.

9. Birthplace: Takoma Park, Md.
(Town, county, and state)

10. Usual occupation: X

11. Industry or business: X

FATHER
12. Name: William L. Browning
13. Birthplace: Maryland

MOTHER
14. Maiden name: Anne Marie Scalera
15. Birthplace: Flushing, N. Y.

16. Informant: William L. Browning
Address: 1102 Greenwood Ave.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Aug. 6th. 1946 (month) (day) (year)

Cemetery or crematory: Mt. Olivet

Location: Washington, D. C.

18. Funeral director: Warner & Pumphrey

Address: Silver Spring, Md.

19. Aug 6 1946 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Aug. 5 1946, at 10:20 P M

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from Aug. 5 1946, to 19..
and that I last saw h.. alive on Aug. 5 1946

Immediate cause of death	DURATION
Premature Birth	
Due to: 2	
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: Robert Anning M.D. or other

Address: 1623 Mass Ave NW Date signed: 8/6/46

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-1

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (170)

CERTIFICATE OF DEATH

C8148

Reg. Dist. No. 714

1. PLACE OF DEATH:

County: Montgomery

City or town: Rural - near Ashton
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Montgomery

City or town: Silver Spring.
(If outside city or town limits, write RURAL and give nearest town)

Street No. 309 Timberwood Ave.
(If rural, give LOCATION)

2.(a) If veteran, name war: no

3. (a) FULL NAME: FREDERICK E BUSH

3. (b) Social Security Number: 176-03-8695

4. Sex: male

5. Color or race: White

6.(a) Single, married, widowed, or divorced: married

6.(b) Name of husband or wife: Sylvia L.

6.(c) If alive, give age ... years

7. Birth date of deceased (mo., day, yr.): Oct. 23rd. 1896

8. AGE: Years 49 Months 9 Days 28 If less than one day ... hrs. ... min.

9. Birthplace: Penna.
(Town, county, and state)

10. Usual occupation: Bricklayer

11. Industry or business: Construction

FATHER

12. Name: Joseph E. Bush

13. Birthplace: Penna.

MOTHER

14. Maiden name: Anna Wetherbee

15. Birthplace: Penna.

16. Informant: Mrs. Sylvia L. Bush

Address: 309 Timberwood Ave. Silver Spg.

17. Removal & Burial Date thereof 8-24-46
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory: Prospect

Location: Stroudsburg, Monroe Co. Pa.

18. Funeral director: Daniel E. Pumphrey

Address: Silver Spring, Md.

19. Aug 22 1946 Josephine M. Schaeffer
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Aug 21 1946 at 3:40 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dep Med Exam case 19... to ... 19...

and that I last saw h... alive on ... 19...

Immediate cause of death	DURATION
Hemorrhage due to severance of left jugular vein	died instantly
Due to: Fracture of frontal bone	
Due to: (left)	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations ... Date of op. ...

Autopsy results ...

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: accidental Date of: 8-21-46

Where did injury occur? near Ashton (City or town) Monty (County) Md (State)

Injured at home, farm, industry, public place (where?): highway

Means of injury: auto accident Injured at work? no

23. SIGNATURE: Frank J. Broschart M.D. Dep Med. Exam. M. D. or other

Address: Gaithersburg Md. Date signed 8-22-46

MARYLAND STATE DEPARTMENT OF HEALTH

68149

2411 N. Charles St., Baltimore (B1-2)

CERTIFICATE OF DEATH

Reg. Dist. No. 216

1. PLACE OF DEATH:
County: Montgomery
City or town: Bethesda (rural)
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, Institution, or street address where death occurred:
U.S. Naval Hospital, Bethesda, Md.
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: County:
City or town: Washington, D.C.
(If outside city or town limits, write RURAL and give nearest town)
Street No. 1710 Swan St. N.W. Wash., D.C.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME: Alfred Bernard CARTER

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	negro	married

6.(b) Name of husband or wife: Mrs. Lillian Carter
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): July 20, 1893

8. AGE: Years	Months	Days	If less than one day
53	0	12	hrs. min.

9. Birthplace: Virginia (Town, county, and state)
10. Usual occupation: Veteran
11. Industry or business

FATHER
12. Name: Randoff Carter
13. Birthplace: Va.

MOTHER
14. Maiden name: Anna Rich
15. Birthplace: Va.

16. Informant: Mrs. Lillian Carter
Address: 1710 Swan St. N.W. Wash., D.C.

17. removal (Burial, cremation, or removal. Which?) Date thereof 8-5-46 (month) (day) (year)
Cemetery or crematory: Central Point (St. Stephen's)
Location: Central Point, Va.
18. Funeral director: W. Ernest W. Jarvis Co.
Address: 4132 U St. N.W. Wash., D.C.

19. 3 August 1946 (Date rec'd by registrar) Mary Charlotte Smith Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 2 August 1946, at 9:33 p.m.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 1 Aug 1946, to 2 Aug. 1946 and that I last saw him alive on 2 Aug 1946

Immediate cause of death	DURATION
Cerebral hemorrhage	48 h.
Due to hypertension	
Due to Chronic glomerulo nephritis	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operation: Date of op.
Autopsy results: As above
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

C. W. Thompson, Lt.Cdr.(MC) USNR
23. SIGNATURE: M. D. or other
Address: USNH Bethesda, Md. Date signed: 8-3-46

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15

8/9/46

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (52-6)

CERTIFICATE OF DEATH

08150

Reg. Dist. No. 216

1. PLACE OF DEATH:
County: Montgomery
City or town: Bethesda, (Rural)
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 2 months 21 days.
Hospital, institution, or street address where death occurred:
U. S. Naval Hospital, Bethesda, Md.
How long in hospital or institution? 2 months 21 days.

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Prince George
City or town: Mt. Rainer
(If outside city or town limits, write RURAL and give nearest town)
Street No. 4002 35th St., Mt. Rainer, Md.
(If rural, give LOCATION)
2.(a) If veteran, name war: World War I.

3.(a) FULL NAME
CAVANAUGH, Chris Columbus VAP

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	W-US	Married

6.(b) Name of husband or wife: Mrs. Pearl I. Cavanaugh
6.(c) If alive, give age ..... years
7. Birth date of deceased (mo., day, yr.) 9-16-92

8. AGE: Years	Months	Days	If less than one day
53	11	6	..... hrs. ..... min.

9. Birthplace: N.Y.
(Town, county, and state)
10. Usual occupation: Veteran
11. Industry or business
FATHER 12. Name: Andrew B. Cavanaugh
FATHER 13. Birthplace: Canada
MOTHER 14. Maiden name: Catherine Nolan
MOTHER 15. Birthplace: Canada
16. Informant: Wife: Mrs. Pearl I. Cavanaugh
Address: 4002 35th St., Mt. Ranier, Md.
17. Burial (Burial, cremation, or removal. Which?) Date thereof 8-26-46 (month) (day) (year)
Cemetery or crematory: Arlington National
Location: Arlington, Va.
18. Funeral director: F. H. Hines D.H. Hines Co.
Address: 2901 14th St., NW, Wash., D.C.
19. aug 27 1946 (Date rec'd by registrar) Mary Charlotte Smith Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 22 Aug 1946, at 4:30 P.M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 1 June 1946 to 22 Aug 1946 and that I last saw h. (?) alive on ..... 19.....

Immediate cause of death	DURATION
CARCINOMA OF BLADDER	
2 GENERALIZED METASTASES	2 yrs.
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....
Autopsy results: CARCINOMA OF BLADDER & GENERALIZED METASTASES
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide ..... Date of .....
Where did injury occur? ..... (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) .....
Means of injury ..... Injured at work?

23. SIGNATURE: Robert E. Fitzgerald M. D. or other
Address: USNH, Bethesda, Md. Date signed 27 Aug 46

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

8/30/46

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (59)

CERTIFICATE OF DEATH

08151

★ Reg. Dist. No. 217

1. PLACE OF DEATH:
County Montgomery
City or town Olney, Maryland
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, Institution, or street address where death occurred: The Montgomery County General Hosp.
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Montgomery
City or town Rockville
(If outside city or town limits, write RURAL and give nearest town)
Street No. Haiti
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME Cooper. (Twin #2).

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	Col.	Single.

6.(b) Name of husband or wife
6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) August 13, 1946

8. AGE: Years	Months	Days	If less than one day
			6 hrs. 50 min.

9. Birthplace Olney, Maryland (Town, county, and state)
10. Usual occupation Infant
11. Industry or business
12. FATHER Name Leroy Addison
13. Birthplace Maryland.
14. MOTHER Maiden name Louise Cooper
15. Birthplace Rockville, Md.
16. Informant Hospital records
Address
17. Cremation (Burial, cremation, or removal. Which?) Date thereof 8-13-46 (month) (day) (year)
Cemetery or crematory Monty. Co. Gen. Hosp. Inc
Location Olney, Md.
18. Funeral director Monty Co. Gen. Hosp. Inc
Address Olney Md
19. 8-13-46 (Date rec'd by registrar) Gertrude B. Lawler Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH August 13 1946, at 7:15 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from August 13 1946, to Aug. 13 1946 and that I last saw her alive on August 13 1946

Immediate cause of death	DURATION
Prematurity	5½ mts
Due to	
Due to —	
Other conditions —	

(Include pregnancy within 3 months of death)

Major findings of operations —
Date of op. —
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide — Date of —
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury — Injured at work? —

23. SIGNATURE [signature] M. D. or other
Address Sandy Spring, Md. Date signed 8/13/46

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-1

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (15-12)

CERTIFICATE OF DEATH

08152

Reg. Dist. No. 3-16

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County Montgomery

City or town Bethesda, Md.
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 24½ hrs.

Hospital, Institution, or street address where death occurred:
Suburban Hosp

How long in hospital or institution? 24½ hrs.

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Maryland County Montgomery

City or town Rockville
(If outside city or town limits, write RURAL and give nearest town)

Street No. .....
(If rural, give LOCATION)

2.(a) If veteran, name war .....

3.(a) FULL NAME Baby Boy Cramer

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	W	

6.(b) Name of husband or wife .....

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) August 23, 1946

8. AGE: ~~Years~~	Months	Days	If less than one day
24½ hrs		1	..... hrs. ..... min.

9. Birthplace Rockville Md.
(Town, county, and state)

10. Usual occupation .....

11. Industry or business .....

FATHER 12. Name Harry Ralph Cramer

FATHER 13. Birthplace Walkersville Maryland

MOTHER 14. Maiden name Catherine Fogle

MOTHER 15. Birthplace Liberty Maryland

16. Informant .....

Address .....

17. Cremation (Burial, cremation, or removal. Which?) Date thereof Aug 27, 1946 (month) (day) (year)

Cemetery or crematory Suburban Hospital

Location Bethesda Md.

18. Funeral director D.B. Dolan Mgr.

Address Bethesda 14. Md.

19. 8/29 1946 (Date rec'd by registrar) Wm E Jabes Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 8-25 1946, at 12-05 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Aug 24 1946, to Aug 25 1946

and that I last saw h. IM alive on Aug 25 1946

Immediate cause of death	DURATION
Congenital Heart Disease	
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations .....

Date of op. .....

Autopsy results Congenital Heart Disease

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE Lelett E. DeLauter M.D.
M. D. or other

Address Suburban Hosp. Bethesda Md. Date signed Aug 27/1946

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (14a)

CERTIFICATE OF DEATH

08153

Reg. Diat. No. 223

1. PLACE OF DEATH:

County Montgomery

City or town Takoma Park

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 22 days.

Hospital, Institution, or street address where death occurred:

Washington Sonitarium and Hospital

How long in hospital or institution? 22 days.

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County ?

City or town Takoma Park.

(If outside city or town limits, write RURAL and give nearest town)

Street No. 507 Green wood

(If rural, give LOCATION)

2.(a) If veteran, name war ?

3. (a) FULL NAME Mr. Charles A. Cruze.

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	Cauc.	Married

6.(b) Name of husband or wife Polly B. Cruze.

6.(c) If alive, give age ? years

7. Birth date of deceased (mo., day, yr.) February 21, 1896

8. AGE: Years	Months	Days	If less than one day
50	5	18	..... hrs. ..... min.

9. Birthplace Knoxville Tenn. (Town, county, and state)

10. Usual occupation Transportation business

11. Industry or business

FATHER 12. Name GEO. DAVID CRUZE

13. Birthplace KNOX COUNTY, TENN.

MOTHER 14. Maiden name MARY EVELYN KIRBY

15. Birthplace KNOX COUNTY, TENN.

16. Informant Records - Washington San. & Hosp.

Address Takoma Park, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Aug 11, 1946. (month) (day) (year)

Cemetery or crematory GEORGE WASH. MEMORIAL CEMETERY

Location RIGGS ROAD, HYATTSVILLE, Md., P.G. Co.

18. Funeral director Arthur Waller

Address 254 Carroll St. N.W. Takoma Park D.C.

19. Aug 9 1946 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH August 8, 1946 at 10:50 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from August 3, 1946, to Aug. 8, 1946 and that I last saw h.i.m. alive on August 8, 1946

Immediate cause of death Coronary thrombosis with infarction — DURATION 25 days

Due to Coronary Arteriosclerosis — 4 years

Due to .....

Other conditions .....

(Include pregnancy within 3 months of death)

Major findings of operations .....

Date of op. .....

Autopsy results Confirm Clinical Diagnosis

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE Wallace N. Mook M.D. M. D. or other

Address Takoma Park Md. Date signed 8-9-46

VS A15 9-45-11

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (73-2)

CERTIFICATE OF DEATH

★ 08154

Reg. Dist. No. 216

1. PLACE OF DEATH:
County: Montgomery
City or town: Bethesda (rural)
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 7 mons. 12 days
Hospital, institution, or street address where death occurred:
U.S. Naval Hospital, Bethesda, Md.
How long in hospital or institution? 12 mons. 12 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Couoty:
City or town: Washington, D.C.
(If outside city or town limits, write RURAL and give nearest town)
Street No. 1922 Bennets Place N.E.
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: Strouder (n) Darnell

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	negro	married

6.(b) Name of husband or wife: Lottie Darnell
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): 18 Feb 1878

8. AGE: Years	Months	Days	If less than one day
68	5	15	hrs. min.

9. Birthplace: Ky.
(Town, county, and state)

10. Usual occupation: Veteran

11. Industry or business:

FATHER
12. Name: Joseph Darnell
13. Birthplace: Va. dec.

MOTHER
14. Maiden name: Eliza Hann
15. Birthplace: Ky. dec.

16. Informant: Mrs. Lottie Darnell
Address: 1922 Bennets Place N.W. Wash., D.C.

17. burial (Burial, cremation, or removal. Which?) Date thereof 8-6-46 (month) (day) (year)
Cemetery or crematory: Lincoln Memorial
Location: Washington, D. C.

18. Funeral director: Clayton A. Washington T.P.
Address: 4925 Deane Avenue, N.E., Wash., D. C.

19. 8-2- 1846 (Date rec'd by registrar) Mary Charlotte Smith Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 2 August 1946 at 0431 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 20 Dec. 1945, to 2 Aug. 1946
and that I last saw h... im alive on 2 Aug. 1946

Immediate cause of death	DURATION
Hypertensive Heart Disease	20 yrs
Due to:	
Due to:	
Other conditions: Congestive Ht. Failure	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;
Accident, suicide, or homicide: Date of:
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?):
Means of injury: Injured at work?

23. SIGNATURE: C. W. Thompson C. W. THOMPSON, Lt.Cdr.(MC) USNR
M. D. or other
Address: USNH Bethesda, Md. Date signed: 8-2-46

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

8/9/46

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 467

CERTIFICATE OF DEATH

08155

Reg. Dist. No. 216

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH:

County: Montgomery

City or town: Bethesda (rural)

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 2 months, 15 days

Hospital, institution, or street address where death occurred:

US Naval Hospital, Bethesda, Md.

How long in hospital or institution? 2 months, 15 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Ohio County:

City or town: Youngstown

(If outside city or town limits, write RURAL and give nearest town)

Street No. 523 Lexington Avenue

(If rural, give LOCATION)

2.(a) If veteran, name war:

3.(a) FULL NAME: DAVIS, Joshua Thomas

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	W-US	single

6.(b) Name of husband or wife:

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): December 31, 1892

8. AGE: Years	Months	Days	If less than one day
53	7	8	hrs. min.

9. Birthplace: Ohio (Town, county, and state)

10. Usual occupation: Navy

11. Industry or business:

FATHER — 12. Name: Thomas Davis

13. Birthplace: Ohio

MOTHER — 14. Maiden name: Jemima ?

15. Birthplace: Ohio

16. Informant: Mother: Mrs. Jemima Davis

Address: 523 Lexington Avenue, Youngstown, Ohio

17. burial (Burial, cremation, or removal. Which?) Date thereof: Aug. 10 1946 (month) (day) (year)

Cemetery or crematory: Belmont

Location: Youngstown, Ohio

18. Funeral director: W. W. Chambers W. W. C.

Address: 1400 Chapin St., N. W., Wash., D.C.

19. 8-9- 1946 (Date rec'd by registrar) Mary Charlotte Smith Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 9 August 1946 at 3:23A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 24 May 1946 to 9 Aug 1946 and that I last saw him alive on 9 Aug 1946

	DURATION
Immediate cause of death: Duodenal Hemorrhage	2 wks
Due to: Carcinoma of Head of Pancreas.	4 mo
Due to: metastasis to liver, Gall Common duct and duodenum	3 mo
Other conditions: Obstruction of Common duct and Duct of Wirsung	

(Include pregnancy within 3 months of death)

Major findings of operations: Chronic Pancreatitis and obstruction of Common Duct Date of op. 6/10/46

Autopsy results: Carcinoma of Head of Pancreas & metastasis to liver & Jaundice

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: J. C. OWENS, Lt. comdr (MC) USNR M. D. or other

Address: USNH Bethesda, Md. Date signed: 8-9-46

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (47d)

CERTIFICATE OF DEATH

C8156

Reg. Diat. No. 223-

1. PLACE OF DEATH:

County: Montgomery

City or town: Takoma Park, 12 Md.
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 2 months 3 days.

Hospital, institution, or street address where death occurred:
Washington Sanitarium and Hospital.

How long in hospital or institution? 2 mos. 3 days.

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give resideoce of mother)

State: District of Columbia County:

City or town: Washington
(If outside city or town limits, write RURAL and give nearest town)

Street No. 2331 Cathedral Ave
(If rural, give LOCATION)

2.(a) If veteran, name war:

3.(a) FULL NAME: Dennistow, Miss Jessie C

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	Cauc.	Single

6.(b) Name of husband or wife:

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): January 12 1869

8. AGE: Years	Months	Days	If less than one day: hrs.	min.
77	8	18		

9. Birthplace: Tomaqua Penna.
(Town, county, and state)

10. Usual occupation: Retired

11. Industry or business: Registered Nurse

FATHER
12. Name: Unable to obtain
13. Birthplace:

MOTHER
14. Maiden name: "
15. Birthplace:

16. Informant: Washington Sanitarium and Hospital
Address: Takoma Park, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Aug 31, 1946 (month) (day) (year)
Cemetery or crematory: Odd Fellows Cemetery
Location: Tomaqua, Penna

18. Funeral director: The S.H. Hines Co
Address: 2901 14th St NW. Wash. D.C.

19. Aug 30 1946 (Date rec'd by registrar) J. W. Dudley Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 30 Aug 1946, at 9 00 am PM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 19 Aug 1946, to 30 Aug 1946
and that I last saw h... alive on 29 Aug 1946

Immediate cause of death	DURATION
Carcinoma Lft lung with metastases to heart, right lung, spleen and regional lymph nodes.	unknown
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.

Autopsy results: as above.

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, Indusfry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: Clemmer J. Brown M.D.
M.D. or other

Address: 4-5 Carroll Ave Tak Pk Date signed: 29 Aug 46

VS A15 9-45-15

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH NONFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (92a)

CERTIFICATE OF DEATH

★ 68157

Reg. Diat. No. 316

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-1

1. PLACE OF DEATH:
County: Montgomery County.
City or town: Bethesda, Maryland.
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 1 Day
Hospital, Institution, or street address where death occurred: Suburban Hospital
How long in hospital or institution? 8-13-46 to 8-14-46.

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Montgomery
City or town: Kensington Md.
(If outside city or town limits, write RURAL and give nearest town)
Street No. 26 Fawcett St.
(If rural, give LOCATION)
2.(a) If veteran, name war: None

3.(a) FULL NAME: Mrs. Pearl Dierdorf

3.(b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F.	W.	Widowed

6.(b) Name of husband or wife: Dead (Benjamin F. Dierdorf) 6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): August 13 1882

8. AGE: Years	Months	Days	If less than one day
64	0	1	— hrs. — min.

9. Birthplace: Virginia (Town, county, and state)
10. Usual occupation: Housewife.
11. Industry or business: Home

FATHER
12. Name: Samuel Adams.
13. Birthplace: Virginia.

MOTHER
14. Maiden name: Fannie Hannaway.
15. Birthplace: Virginia.

16. Informant: Daughter
Address: Abode address

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Aug. 16, 1946 (month) (day) (year)
Cemetery or crematory: Rockville Union Cemetery
Location: Rockville, Maryland

18. Funeral director: W Reuben Trumpfheller
Address: Bethesda, Maryland

19. Aug 14 1946 (Date rec'd by registrar) Wm E Jobes Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: August 14 1946 at 4:50 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Aug. 7 1946 to Aug. 14 1946 and that I last saw h.e.v. alive on Aug 14 1946

Immediate cause of death	DURATION
a. Embolism; Peripheral	3 hours
b. Left Common Iliac Arteries	
Due to: Secondary to Auricular Fibrillation	8-10 yrs.
Due to:	
Other conditions: Hypertensive Heart Disease with C.H.F.	8-10 yr.

(Include pregnancy within 3 months of death)

Major findings of operations: Embolectomy performed 8/14/46 - with incision 3-4 hours - Cardiac Arrest Date of op. 8/14/46

Autopsy results: — NONE

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following: X
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: Samuel Allen M. D. or other
Address: 196 Fawcett - Kensington, Md. Date signed: 8/14/46

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (57-P)

CERTIFICATE OF DEATH

08158

Reg. Diat. No. 216

1. PLACE OF DEATH:

County: Montgomery

City or town: Bethesda, Md.

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 4 days

Hospital, institution, or street address where death occurred: Suburban Hospital

How long in hospital or institution? Since 8/11/46

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Montgomery

City or town: Gaithersburg

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Baby Ralph Clinton Earp

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	W.	S

6.(b) Name of husband or wife: father

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): August 11, 1946

8. AGE: Years | Months | Days: 4 | If less than one day: ..... hrs. ..... min.

9. Birthplace: Bethesda Maryland

(Town, county, and state)

10. Usual occupation

11. Industry or business

FATHER

12. Name: Henry Earp

13. Birthplace: Germantown, Md.

MOTHER

14. Maiden name: Esther Clark

15. Birthplace: Pennsylvania

16. Informant: Henry Earp (father)

Address: Gaithersburg Maryland

17. (Burial, cremation, or removal. Which?) CREMATION Date thereof (month) Aug (day) 17 (year) 1946

Cemetery or crematory: SUBURBAN HOSPITAL

Location: 8600 Old Georgetown - BETHESDA 14, MD

18. Funeral director: A. B. Solon / Supt

Address: above

19. (Date rec'd by registrar) 8/19/46 Wm E Jobes Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH August 15 1946, at 1:30 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from August 11, 1946, to August 15, 1946

and that I last saw h.. on alive on ..... 19.....

Immediate cause of death	DURATION
Coarctation of Aorta	
Edema of Larynx	
Anoxemia	
Due to Coarctation, ruptured	
Pernicious hypoxemia	
Due to and edema of brain	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE R. Stansfield M.D.

M. D. or other

Address 7824 Wisconsin Ave Bethesda Date signed 8/16/46

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (50) f

CERTIFICATE OF DEATH

C8159 216

Reg. Dist. No. 367

1. PLACE OF DEATH:

County Montgomery

City or town Chevy Chase
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 9 years

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Maryland County Montgomery

City or town Chevy Chase
(If outside city or town limits, write RURAL and give nearest town)

Street No. 511 Rolling Road
(If rural, give LOCATION)

2.(a) If veteran, name war No

3. (a) FULL NAME MILDRED HAMILTON FALLOWFIELD

3. (b) Social Security Number NONE

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Married

6.(b) Name of husband or wife Frank Paul Fallowfield 6.(c) If alive, give age 51 years

7. Birth date of deceased (mo., day, yr.) December 14, 1898

8. AGE: Years	Months	Days	If less than one day
47	7	24	..... hrs. ..... min.

9. Birthplace Baltimore, Maryland
(Town, county, and state)

10. Usual occupation Housewife

11. Industry or business

FATHER 12. Name Wiley Carroll Hamilton

13. Birthplace Baltimore, Maryland

MOTHER 14. Maiden name Floyd Wortham

15. Birthplace Middlesex, Virginia

16. Informant Frank Paul Fallowfield

Address 511 Rolling Rd. Chevy Chase, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof Aug. 10, 1946 (month) (day) (year)

Cemetery or crematory Woodlawn Cemetery

Location Baltimore, Maryland

18. Funeral director Wm. Lawton Pumphrey

Address Bethesda, Maryland

19. 8/9 1946 Wm E Jabes Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug. 8, 1946, at 8 A. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan 1946, to 8 Aug 1946 and that I last saw her alive on 8 Aug 1946

Immediate cause of death	DURATION
Adenocarcinoma, cerebral, metastatic from left breast	3 mos.
Due to Adenocarcinoma, left breast	8 yrs.
Due to	
Other conditions Generalised metastases from breast carcinoma (Include pregnancy within 3 months of death)	

Major findings of operation

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide — Date of —

Where did injury occur? — (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) —

Means of injury Injured at work?

23. SIGNATURE Stewart Ladd, M.D. M. D. or other

Address 3921 Ingomar St. Wash. D.C. Date signed 8-8-46

VS A15 9-45-15

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (94a)

08160

CERTIFICATE OF DEATH

Reg. Dist. No. 223

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45

1. PLACE OF DEATH:
County Montgomery
City or town Takoma Park
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 2 hrs. 25 min.
Hospital, institution, or street address where death occurred: Washington Sanitarium and Hosp.
How long in hospital or institution? 2 hrs 25 min.

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Montgomery
City or town Takoma Park
(If outside city or town limits, write RURAL and give nearest town)
Street No. Washington Missionary College
(If rural, give LOCATION) Central Hall
2.(a) If veteran, name war

3. (a) FULL NAME Carrie Feltus

3. (b) Social Security Number

4. Sex Fe
5. Color or race Cauc.
6.(a) Single, married, widowed, or divorced widowed
6.(b) Name of husband or wife James Feltus.
6.(c) If alive, give age ... years
7. Birth date of deceased (mo., day, yr.) April 12, 1875

8. AGE: Years 71 Months 4 Days 4 If less than one day ... hrs. ... min.

8. Birthplace Vinal Haven, Maine (Town, county, and state)
10. Usual occupation Retired
11. Industry or business

FATHER
12. Name James Norton
13. Birthplace Maine.

MOTHER
14. Maiden name Lydia Phillips
15. Birthplace Mass.

16. Informant Records - Washington San. & Hosp.
Address Takoma Park, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Aug 19, 1946 (month) (day) (year)
Cemetery or crematory Geo. Wash. Memorial Cemetery
Location Riggs Road Hyattsville Md. Pr. Geo. Co.

18. Funeral director [illegible] Walters
Address 25 Carroll St., Takoma Park D.C.

19. Aug. 16 1946 (Date rec'd by registrar) [illegible signature] Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug 16 1946 at 3:00 A. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ... 19... to ... 19...
Dep. Med. Exam. Case
and that I last saw h... alive on ... 19...

	DURATION
Immediate cause of death Coronary occlusion	2 hrs.
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations ... Date of op. ...
Autopsy results same as above
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide ... Date of ...
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury ... Injured at work?

23. SIGNATURE Frank J. Broschart M.D.
Dep. Med. Exam.
M. D. or other
Address Gaithersburg Md. Date signed 8-16-46

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (W)

CERTIFICATE OF DEATH

★ 08161

Reg. Dist. No. 216

1. PLACE OF DEATH:

County: Montgomery

City or town: Bethesda (rural)
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 7 hours

Hospital, institution, or street address where death occurred:
US Naval Hospital, Bethesda, Md.

How long in hospital or institution? 7 hours

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: ____ County: ____

City or town: Washington, D. C.
(If outside city or town limits, write RURAL and give nearest town)

Street No. 76 New York Avenue, N. W.
(If rural, give LOCATION)

2.(a) If veteran, name war: ____

3.(a) FULL NAME: FILLMORE, Ernest (n)

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	W-US	married

6.(b) Name of husband or wife: Winifred Fillmore

6.(c) If alive, give age: ____ years

7. Birth date of deceased (mo., day, yr.): 19 March 1903

8. AGE: Years	Months	Days	If less than one day
43	5	10	____ hrs. ____ min.

9. Birthplace: Michigan
(Town, county, and state)

10. Usual occupation: veteran

11. Industry or business: ____

FATHER
12. Name: Frederick Fillmore
13. Birthplace: Michigan

MOTHER
14. Maiden name: Bertha Wood
15. Birthplace: Michigan

16. Informant: wife: Mrs. Winifred Fillmore
Address: 76 New York Avenue, N.W., Wash., D.C.

17. burial — Date thereof: 9-3-46
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory: Arlington National

Location: Arlington, Va.

18. Funeral director: W. W. CHAMBERS L.L. Chambers Co. F.J.K.

Address: 1400 Chapin St., N. W. Wash., D.C.

19. 8-29 46 Mary Charlotte Smith
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 29 Aug. 1946, at 5:05 AM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 28 Aug. 1946, to 29 Aug 1946 and that I last saw h... im ...alive on 29 August 1946

Immediate cause of death	DURATION
Pneumonia, lobular	7 days
Due to:	
Due to:	
Other conditions: Fatty cirrhosis	
Diabetes mellitus	10 yrs

(Include pregnancy within 3 months of death)

Major findings of operation: ____ Date of op. ____

Autopsy results: Pneumonia, lobular & fatty cirrhosis

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ____ Date of ____

Where did injury occur? ____ (City or town) (County) (State)

Injured at home, farm, industry, public place (where?): ____

Means of injury: ____ Injured at work?

23. SIGNATURE: T. S. Barnes
T. S. BARNES, Lt.Cdr.(MC) USN
M. D. or other

Address: USNH Bethesda, Md. Date signed: 8-29-46

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15

9/5/46

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (13-A)

CERTIFICATE OF DEATH

★ (8162) Reg. Dist. No. 7/14

1. PLACE OF DEATH:

County: Montgomary

City or town: Silver Spring (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State: County:

City or town: Washington, D.C. (If outside city or town limits, write RURAL and give nearest town)

Street No.: 1305 Irving St. N.W. (If rural, give LOCATION)

2.(a) If veteran, name war:

3.(a) FULL NAME: Emma Marie Fogerty

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	

6.(b) Name of husband or wife: James

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Oct. 11, 1862

8. AGE: Years	Months	Days	If less than one day: hrs.	min.
83				

9. Birthplace: Wisconsin (Town, county, and state)

10. Usual occupation:

11. Industry or business:

FATHER — 12. Name: Dana Clements; 13. Birthplace: Vermont

MOTHER — 14. Maiden name: Betsy Newcombe; 15. Birthplace: Vermont

16. Informant: Mrs. Watie Johnson

Address: 1305 Irving Street N. W.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Aug. 20, 1946 (month) (day) (year)

Cemetery or crematory: Ft. Lincoln Cemetery

Location: Bladensburg Rd. Washington, D.C.

19. Funeral director: L H Hines Co

Address: 2901-14th St N.W. Wash. D.C.

19. (Date rec'd by registrar) 19 Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Aug. 17 19 46 at 5:15 AM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 19 41, to Aug. 16 19 46

and that I last saw h[illegible] alive on Aug. 16 19 46

	DURATION
Immediate cause of death: Chronic hypertension	
Due to: Cardio-vascular-Renal disease	
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: R S Williams M. D. or other

Address: 35 New York Ave. NW Date signed: 8/17/46

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (13:a)

CERTIFICATE OF DEATH

08163

Reg. Dist. No. 216

1. PLACE OF DEATH:
County: Montgomery
City or town: Bethesda (rural)
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 1 days
Hospital, institution, or street address where death occurred:
US Naval Hospital, Bethesda, Md.
How long in hospital or institution? 1 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Va. County: Arlington
City or town: Arlington
(If outside city or town limits, write RURAL and give nearest town)
Street No.: 2139 Stafford Street
(If rural, give LOCATION)
2.(a) If veteran, name war: 1st World War

3.(a) FULL NAME: FRENCH, William Thomas

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	W-US	married

6.(b) Name of husband or wife: Mrs. Shirley French
6.(c) If alive, give age: ..... years

7. Birth date of deceased (mo., day, yr.): August 2, 1891

8. AGE: Years	Months	Days	If less than one day
55	0	4	..... hrs. ..... min.

9. Birthplace: Va. (Town, county, and state)
10. Usual occupation: Veteran
11. Industry or business

FATHER
12. Name: William H. French
13. Birthplace: Va.

MOTHER
14. Maiden name: Henretta A. Maffett
15. Birthplace: Va.

16. Informant: wife: Mrs. Shirley French
Address: 2139 Stafford St., Arlington, Va.

17. burial (Burial, cremation, or removal. Which?) Date thereof 8-9-46 (month) (day) (year)
Cemetery or crematory: Arlington National
Location: Arlington, Va.

18. Funeral director: W. W. CHAMBERS (Coons)
Address: Georgetown, D. C. Mary Charlotte Smith

19. 8-6 19 46 Mary Charlotte Smith
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 6 August 19 46 at 2:20 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 5 August 19 46 to 6 Aug. 19 46 and that I last saw him alive on 6 August 19 46

Immediate cause of death: Cerebral hemorrhage — DURATION: 12 hours
Due to: Hypertension, essential
Due to: Arteriolar nephrosclerosis
Other conditions:
(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....
Autopsy results: as above

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: ..... Date of .....
Where did injury occur? ..... (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) .....
Means of injury ..... Injured at work?

23. SIGNATURE: C. W. THOMPSON
Address: USNH Bethesda, Md. M. D. or other
Date signed: 8-6-46

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

8/9/46

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (170-C)

CERTIFICATE OF DEATH

Reg. Dist. No. 08164 216

1. PLACE OF DEATH:
County: Montgomery
City or town: Bethesda, (Rural)
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 8 days
Hospital, institution, or street address where death occurred:
U. S. NAVAL HOSPITAL, BETHESDA, MD.
How long in hospital or institution? 8 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: County: St. Marys
City or town: Great Mills, Maryland.
(If outside city or town limits, write RURAL and give nearest town)
Street No.:
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: FULLMER, Lawrence Donald AMM1c, USN.

3.(b) Social Security Number: 258 36 15.

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	W-US	Married

6.(b) Name of husband or wife: Mrs. Lyda Fullmer
6.(c) If alive, give age: 18 years

7. Birth date of deceased (mo., day, yr.): 10-28-23

8. AGE: Years	Months	Days	If less than one day
22	10	1	...hrs. ...min.

9. Birthplace: Pa.
(Town, county, and state)
10. Usual occupation: U.S. Navy
11. Industry or business:

FATHER
12. Name: Lon Fullmer
13. Birthplace: W.Va.

MOTHER
14. Maiden name: Elizatheth Dengg
15. Birthplace: Pa.

16. Informant: Mrs. Lyda Fullmer
Address: Great Mills, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Aug. 29, 1946 (month) (day) (year)
Cemetery or crematory: Masontown
Location: Masontown, W.Va.

18. Funeral director: Derring & Son W W C
Address: Morgantown, W.Va.

19. Aug 24 1946 (Date rec'd by registrar) Mary Charlotte Smith Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Aug 24 1946, at 5:30 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Aug 24 1946, to Aug 24 1946
and that I last saw h... alive on Aug 24 1946

Immediate cause of death	DURATION
Lobar pneumonia	4 days
Pulmonary edema	4 days
Due to: Bleeding with effusion	4 days
Due to: Fracture L left hip (accidental)	8 days
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operation: ... Date of op.:
Autopsy results: same as above
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Accident Date of: 8-16-46
Where did injury occur? Middleburg (City or town) Va (County) (State)
Injured at home, farm, industry, public place (where?): highway
Means of injury: auto accident Injured at work? no

23. SIGNATURE: Frank J. Bovasso M.D. M. D. or other
Dep. Med. Exam.
Address: Gaithersburg, Md Date signed: 8-24-46

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly

VS A15 9-45-15M

8/30/46

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

★ 8165

Reg. Dist. No. 223

1. PLACE OF DEATH:

County: Montgomery

City or town: Takoma Park
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:
506 Carroll Avenue

How long in hospital or institution? 3 years

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Virginia County: Alexandria

City or town: Alexandria
(If outside city or town limits, write RURAL and give nearest town)

Street No. 724 So. Asaph St
(If rural, give LOCATION)

2.(a) If veteran, name war: No

3. (a) FULL NAME: JOSEPH GAUZZA

3. (b) Social Security Number: No

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Rosa Gauzza

6.(c) If alive, give age: ..... years

7. Birth date of deceased (mo., day, yr.): May 5, 1870

8. AGE: Years	Months	Days	If less than one day
76	3	1	..... hrs. ..... min.

9. Birthplace: Italy
(Town, county, and state)

10. Usual occupation: Paper hanger.

11. Industry or business: Own business.

FATHER
12. Name: Unknown
13. Birthplace: Italy

MOTHER
14. Maiden name: Unknown
15. Birthplace: Italy

16. Informant: Mrs. Matilda Dellacasa

Address: 3361 Military Rd., N.W. D.C.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Aug. 22, 1946 (month) (day) (year)

Cemetery or crematory: St. Mary's Cemetery

Location: Washington, D. C.

18. Funeral director: L. H. Hines Co.

Address: 2901-14th St., N.W. D. C.

19. Aug 22 1946 (Date rec'd by registrar) J. Wilson Dodd Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Aug 20 1946, at 6:30 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan 1, 1946, to Aug 20, 1946, and that I last saw him alive on Aug 20 1946

Immediate cause of death	DURATION
Broncho-Pneumonia-Terminal	3 Days
Due to	
Due to	
Other conditions: Arterio-Sclerosis-Gen. Hypertension	1 Yr.

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....

Autopsy results: .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE: Louis P. Leivo, M.D.
M. D. or other

Address: 200 Mass. Ave NW Date signed: 8-20-46

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

08166

Reg. Dist. No. 223

1. PLACE OF DEATH:
County: Montgomery
City or town: Takoma Park-6
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 30 yrs
Hospital, institution, or street address where death occurred: 720 - Flower Ave
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Montgomery
City or town: Takoma Park
(If outside city or town limits, write RURAL and give nearest town)
Street No. 720 - Flower Ave
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME: Ed. Frederick Barnes Gilbert.

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M.	W	Widowed

6.(b) Name of husband or wife: Ella Mary Gilbert
6.(c) If alive, give age ____ years

7. Birth date of deceased (mo., day, yr.): Sept. 30-1867

8. AGE:

Years	Months	Days	If less than one day
078	11	1	____ hrs. ____ min.

9. Birthplace: London, England (Town, county, and state)
10. Usual occupation: Minister
11. Industry or business: General Conference of S.D.A.

FATHER
12. Name: Unknown
13. Birthplace

MOTHER
14. Maiden name
15. Birthplace

16. Informant: Ruth Gilbert Miller
Address: 5875 Delaware St. Indianapolis Ind

17. Burial, cremation, or removal: Buried
Date thereof: Sept 4 - 1946 (month) (day) (year)
Cemetery or crematory: Mount Lancaster Cemetery
Location: Mount Lancaster Mass.

18. Funeral director: Arthur Walter
Address: 254 Carroll Takoma Park

19. Aug 31 1946 (Date rec'd by registrar)
Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Aug 31 1946 at 6:30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from March 1943 to Aug 31, 1946 and that I last saw h alive on Aug 30, 1946

Immediate cause of death	DURATION
Cerebral hemorrhage	3 ± yrs
with hemiplegia	
Due to: Arteriosclerosis.	years.
Due to:	
Other conditions: Coronary disease	3 ± yrs
Prostatic Hypertrophy	years.

(Include pregnancy within 3 months of death)

Major findings of operations: None
Date of op.
Autopsy results: None

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: Read n. Calvert M.D.
M. D. or other
Address: 7894 Ga Ave Silver Spring Md
Date signed: 8-31-46

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (93-d)

CERTIFICATE OF DEATH

08471

Reg. Dist. No. 223-

1. PLACE OF DEATH:
County: Montgomery
City or town: Takoma Park, Md.
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md. County:
City or town: Takoma
(If outside city or town limits, write RURAL and give nearest town)
Street No. 7322 - Piney Branch Rd.
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: Bertha Miller Gordon

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widowed

6.(b) Name of husband or wife: Arthur Franklin Gordon
6.(c) If alive, give age: years
7. Birth date of deceased (mo., day, yr.): Aug - 28 - 1875

8. AGE: Years	Months	Days	If less than one day
70		11	hrs. min.

9. Birthplace: Indiana (Town, county, and state)
10. Usual occupation: Housewife
11. Industry or business

FATHER
12. Name: James Miller
13. Birthplace: Indiana

MOTHER
14. Maiden name: Muthemmey
15. Birthplace: Indiana

16. Informant: Bertha A Gordon
Address: 7322 Piney Branch Rd.

17. (Burial, cremation, or removal. Which?) Date thereof (month) (day) (year)
Cemetery or crematory: Cedar Hill Aug 8
Location:

18. Funeral director: S H. Hines Co
Address: 2901 - 14 St N.W.

19. Aug 6 19 46 (Date rec'd by registrar) J H Redlon Deputy Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 5 August 19 46, at 11 40 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 3 August 19 46 to 5 August 19 46 and that I last saw her alive on 5 August 19 46

Immediate cause of death	DURATION
Cerebral Hemorrhage	60 hours.
Due to: Hypertensive Heart Disease	34 years.
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations: ~
Date of op.:
Autopsy results: none
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, Industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: J B Queen M.D.
M. D. or other
Address: 112 Willow Ave. Takoma Park, Md. Date signed 5 Aug 1946

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (83a)

CERTIFICATE OF DEATH

Reg. Dist. No. 08167 5-14

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Give correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH:

County Montgomery

City or town Silver Spring
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? ----

~~XXXXXXXXXXXX~~ street address where death occurred:
9 Belmont Court

How long in hospital or institution? ----

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Maryland County Montgomery

City or town Silver Spring
(If outside city or town limits, write RURAL and give nearest town)

Street No. 9 Belmont Court
(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME

AMY HUSSEY GRAHAM

3.(b) Social Security Number

none

4. Sex	5. Color or race	8.(a) Single, married, widowed, or divorced
female	white	widowed

6.(b) Name of husband ~~XXXX~~ Albert F. Graham

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) Dec. 14, 1869

8. AGE: Years	Months	Days	If less than one day
76	8	0	....hrs. ....min.

9. Birthplace Brazil, Indiana
(Town, county, and state)

10. Usual occupation Retired Government Employee;

11. Industry or business school teacher; writer

FATHER
12. Name Edward H. Hussey
13. Birthplace Carlisle, Indiana

MOTHER
14. Maiden name Mary Basset
15. Birthplace Canfield, Ohio

16. Informant Misses Edith M. & Lucia Hussey, sisters
Address 9 Belmont Court, Silver Spring, Md.

17. Cremation Date thereof Aug. 16, 1946
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Fort Lincoln Crematory

Location Bladensburg Rd., Md.

18. Funeral director Warner E. Pumphrey

Address Silver Spring, Maryland

19. Aug 15 1946 Josephine M. Schaeffer
(Date received by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH August 14 1946, at 5:15 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 16 1940 to Aug 14 1946 and that I last saw h~~e~~ alive on Aug 14 1946

Immediate cause of death	DURATION
Cerebral Hemorrhage	
Due to Hypertension	
Due to Arteriosclerosis, generalized	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations ..... Date of op. .....

Autopsy results .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE Dean W. Harding M.D.
M. D. or other

Address 113 Carroll St Date signed Aug. 15, 1946

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (94a)

08168

CERTIFICATE OF DEATH

Reg. Diat. No. 714

1. PLACE OF DEATH:

County: Montgomery

City or town: Silver Spring (Hillendale)
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, Institution, or street address where death occurred:
Overlook Drive

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Montgomery

City or town: Silver Spring
(If outside city or town limits, write RURAL and give nearest town)

Street No. 8201 Queen Annes Drive
(If rural, give LOCATION)

2.(a) If veteran, name war: no

3.(a) FULL NAME: Welford F Hairfield

3.(b) Social Security Number: none

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	white	widowed

6.(b) Name of husband or wife: Corrine E.

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Aug. 29th. 1885

8. AGE: Years	Months	Days	If less than one day
60	11	25	hrs. min.

9. Birthplace: Virginia
(Town, county, and state)

10. Usual occupation: Retired Farmer

11. Industry or business:

FATHER — 12. Name: Flanda Hairfield
13. Birthplace: Virginia

MOTHER — 14. Maiden name: Agnes Taylor
15. Birthplace: Virginia

16. Informant: Mrs. James T. Jones
Address: Avenel Rd. Silver Spring

17. Burial (Burial, cremation, or removal. Which?) Date thereof 8-27-1946 (month) (day) (year)

Cemetery or crematory: Payts

Location: Payts, Orange Co. Va.

19. Funeral director: Warner E Pumphrey

Address: Silver Spring, Md.

19. Aug 26 1946 (Date rec'd by registrar) Josephine M Schaffe Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Aug 24 19 46 at 3:40 P. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sept 19 to 19

and that I last saw h alive on Aug 24 19

Immediate cause of death: Coronary occlusion — DURATION: died suddenly

Due to:

Due to:

Other conditions:

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: Frank J. Brosnahan M.D. M. D. or other

Address: Gaithersburg Md. Date signed: 8-24-46

VS A15 9-45-15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (19)

CERTIFICATE OF DEATH

08169

Reg. Dist. No. 217

1. PLACE OF DEATH:

County Montgomery

City or town Olney, Maryland.
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, Institution, or street address where death occurred:
The Montgomery County General Hospital

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Maryland County Montgomery

City or town Silver Spring
(If outside city or town limits, write RURAL and give nearest town)

Street No. R#2 - near Colesville
(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Hall

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male.	colored ~~White~~	—

8.(b) Name of husband or wife —

8.(c) If alive, give age ____ years

7. Birth date of deceased (mo., day, yr.) August 12, 1946

8. AGE: Years | Months | Days | If less than one day: 1 hrs. 03 min.

9. Birthplace Olney, Montgomery County, Md.
(Town, county, and state)

10. Usual occupation Infant.

11. Industry or business

FATHER — 12. Name William Myers

13. Birthplace Howard Co. Md.

MOTHER — 14. Maiden name Odessa Lee Hall

15. Birthplace Jarrett, Virginia.

16. Informant Hospital records.

Address

17. Cremation (Burial, cremation, or removal. Which?) Date thereof 8-12-46 (month) (day) (year)

Cemetery or crematory Monty. Co. Gen. Hospital Inc

Location Olney, Md.

18. Funeral director Montg. Co. Gen. Hospital

Address Olney, Md.

19. 8-12-1946 (Date rec'd by registrar) Gertrude B. Lawson Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH August 12 1946, at 3:00 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from August 12 1946, to August 12 1946 and that I last saw h.i.m. alive on August 12 1946

Immediate cause of death	DURATION
Prematurity	1/2 mo.
Due to UNKNOWN	—
Due to	
Other conditions —	

(Include pregnancy within 3 months of death)

Major findings of operations —

Date of op.

Autopsy results —

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide. Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of Injury Injured at work?

23. SIGNATURE [signature] M. D. or other

Address Sandy Spring Md. Date signed 8/13/46

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-1

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (83-a)

CERTIFICATE OF DEATH

08170

Reg. Dist. No. 223

1. PLACE OF DEATH:

County: Montgomery

City or town: Takoma Park, Md.

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 5 hrs.

Hospital, Institution, or street address where death occurred: Washington Sanitarium & Hospital

How long in hospital or institution? 5 hrs.

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: D. C. County:

City or town: Fairfax Wash. D. C.

(If outside city or town limits, write RURAL and give nearest town)

Street No. 2128 Southland Terrace

(If rural, give LOCATION)

2.(a) If veteran, name war:

3.(a) FULL NAME: Mrs. Willa Hall

3.(b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Fe	W	Married

6.(b) Name of husband or wife: Mr. John Hall

6.(c) If alive, give age: ..... years

7. Birth date of deceased (mo., day, yr.): Oct. 4, 1889

8. AGE: Years	Months	Days	If less than one day: hrs.	min.
56	10	16		

9. Birthplace: Temple Tex. (Town, county, and state)

10. Usual occupation: Housewife

11. Industry or business:

FATHER — 12. Name: Mr Willy Tidwell

13. Birthplace: Kentucky

MOTHER — 14. Maiden name: Monty Lipton

15. Birthplace: Lampasas, Tex.

16. Informant: Mr. John Hall

Address: 2129 Southland Terrace, Wash.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 8-21-46 (month) (day) (year)

Cemetery or crematory:

Location: Waco, Texas

18. Funeral director: W. M. Tee Sons Co

Address: 1300 - 4 St N.E. - DC

19. Aug 21 19 46 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Aug. 20 19 46, at 4:05 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from January 19 44, to Aug 20 19 46

and that I last saw her alive on Aug 20 19 46

	DURATION
Immediate cause of death: Intracerebral hemorrhage	1 hrs
Due to: arteriosclerosis	years
Due to: Hypertension	years
Other conditions: Hypothyroid Arthritis	3 yrs

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.:

Autopsy results: Confirm above diagnoses.

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: Robert A. Hare M.D. M. D. or other

Address: Takoma Park, Md. Date signed: 8/20/46

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (37-C)

CERTIFICATE OF DEATH

08171 P 217

Reg. Dist. No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH:

County Montgomery

City or town Olney, Maryland.
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred: The Montgomery County General Hospital

How long in hospital or institution? 38 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Maryland County Howard

City or town Ellicott City
(If outside city or town limits, write RURAL and give nearest town)

Street No.
(If rural, give LOCATION)

2.(a) If veteran, name war ✓

3. (a) FULL NAME Joshua Hammond.

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	Colored	Married.

6.(b) Name of husband or wife MARY

6.(c) If alive, give age 50 years

7. Birth date of deceased (mo., day, yr.) MAY 30. 1879

8. AGE: Years	Months	Days	If less than one day
57	2	4	hrs. min.

9. Birthplace Howard Co. Md.
(Town, county, and state)

10. Usual occupation FARMER

11. Industry or business —

FATHER 12. Name Joshua Hammond.

13. Birthplace HOWARD Co Md

MOTHER 14. Maiden name CARRE SMITH

15. Birthplace HOWARD Co Md

16. Informant Hospital records

Address

17. Burial (Burial, cremation, or removal. Which?) Date thereof August 9. 1946 (Month) (day) (year)

Cemetary or crematory Holland Cemetery

Location Howard Cunty Maryland

18. Funeral director Joseph A. Sisk Funeral Home

Address 66 West Baltimore Baltimore Md

19. 8/6 19 46 P.W. Hedrick Registrar

(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH August 3 1946, at 11:15P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 26 1946, to August 3 1946 and that I last saw h.. alive on August 3 1946

Immediate cause of death	DURATION
Uraemia	5 days
Due to Hypertrophied prostate	
Due to Urinary retention	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operation Cystotomy

Data of op. July 5, 1946

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide — Date of —

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury — Injured at work? —

23. SIGNATURE [signature] M. D. or other

Address Sandy Spring, Md Date signed 8-4-46

Over

The age statement is inconsistent with the birth year. After inquiry at the hospital we find that evidence as to the age is confused.

AWH
n

11/6/46

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

08172

CERTIFICATE OF DEATH

Reg. Dist. No. 216

1. PLACE OF DEATH:
County: Montgomery
City or town: Bethesda (Rural)
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 4 mo., 4days.
Hospital, institution, or street address where death occurred:
U. S. NAVAL HOSPITAL, Bethesda, Md.
How long in hospital or institution? 4 mo., 4 days.

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: ..... County: .....
City or town: Washington, D.C.
(If outside city or town limits, write RURAL and give nearest town)
Street No. 303 Livingston St., SE
(If rural, give LOCATION)
2.(a) If veteran, name war: .....

3.(a) FULL NAME: HINKLE, Paul Luther

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	W-US	Married

6.(b) Name of husband or wife: Marion J. Hinkle
6.(c) If alive, give age: ..... years

7. Birth date of deceased (mo., day, yr.): Jan. 5, 1897

8. AGE: Years	Months	Days	If less than one day
49	7	2	..... hrs. ..... min.

9. Birthplace: Pa.
(Town, county, and state)
10. Usual occupation: Veteran
11. Industry or business: .....

FATHER
12. Name: Harry Hinkle
13. Birthplace: Va.

MOTHER
14. Maiden name: Emma Curans
15. Birthplace: Pa. (dec)

16. Informant: Wife, Mrs. Marion J. Hinkle
Address: 303 Livingston St.SE, Wash.D.C.

17. burial (Burial, cremation, or removal. Which?) Date thereof: Aug. 12, 1946 (month) (day) (year)
Cemetery or crematory: Arlington National
Location: Arlington, Va.

18. Funeral director: S. H. Hines ARP.
Address: 2901 14th NW., Wash., D.C.

19. 8 August 1946 (Date rec'd by registrar) Mary Charlotte Smith Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 7 August 1946 at 10:40P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 3 April 1946 to 7 August 1946 and that I last saw him alive on 7 August 1946

	DURATION
Immediate cause of death: Hypostatic Pneumonia.	2 d.
Due to: Cardiac Decompensation	5 d
Due to: Generalized Thrombangeitis Obliterans	4 y.
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operation: .....
Date of op. .....
Autopsy results: .....
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: ..... Date of .....
Where did injury occur? ..... (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) .....
Means of injury ..... Injured at work?

23. SIGNATURE: J.C. DUNN, Comdr.(MC) USN. M. D. or other
Address: USNH Bethesda, Md Date signed: 8-8-46

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15

9/13/46

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

★ 08173

Reg. Dist. No. 211

1. PLACE OF DEATH:

County: Montgomery

City or town: Clarksburg rural MD.
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? Six Months

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Montgomery

City or town: Clarksburg MD.
(If outside city or town limits, write RURAL and give nearest town)

Street No.
(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME: Luther Hosley

3.(b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	Col	Single

6.(b) Name of husband or wife

6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.): May 16.1874

8. AGE: Years	Months	Days	If less than one day
72	3	2	hrs. min.

9. Birthplace: Montgomery MD.
(Town, county, and state)

10. Usual occupation: Labor

11. Industry or business: Farm

FATHER
12. Name: John Hosley
13. Birthplace: Montgomery Co.

MOTHER
14. Maiden name: Catherin Potts
15. Birthplace: Montgomery CO MD.

16. Informant: Emma Butler

Address: Clagettsville MD.

17. Burial (Burial, cremation, or removal. Which?) Date thereof August 20 1946 (month) (day) (year)

Cemetery or crematory: Friendship MD

Location: Clagettsville MD

18. Funeral director: Roy W. Barber

Address: Laytonsville MD.

19. Aug 19 1946 (Date rec'd by registrar) Della N. Burdett Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: August 18, 1946, at 1:00 P. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from November 16, 1941 to August 18 1946.

and that I last saw him alive on August 17, 1946.

Immediate cause of death: Cerebral Hemorrhage, right — DURATION: 5 Days.

Due to: Arteriosclerotic cardiovascular disease. — 15 years.

Due to:

Other conditions:

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: James T. Kerr M.D.
M. D. or other

Address: Dickerson, Md. Date signed: 8/19/46.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-1

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 18

CERTIFICATE OF DEATH

08174

Reg. Dist. No. 213

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County: Montgomery
City or town: Rockville, Maryland
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? Life
Hospital, institution, or street address where death occurred:
West End Park, Rockville, Maryland
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Montgomery
City or town: Rockville, Maryland
(If outside city or town limits, write RURAL and give nearest town)
Street No.: West End Park
(If rural, give LOCATION)
2.(a) If veteran, name war: No

3.(a) FULL NAME: Harry Y. Howes

3.(b) Social Security Number: 578-07-8084

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Widowed

6.(b) Name of husband or wife: Bessie L. Howes

6.(c) If alive, give age: ..... years

7. Birth date of deceased (mo., day, yr.): July 2, 1874

8. AGE: Years	Months	Days	If less than one day
72	1	14	..... hrs. ..... min.

9. Birthplace: Sunshine, Montg. Co. Maryland
(Town, county, and state)

10. Usual occupation: Contactor & Builder, Retired

11. Industry or business

FATHER
12. Name: Julian Howes
13. Birthplace: Rockville, Montg. Co. Md.

MOTHER
14. Maiden name: Sadonia Allen
15. Birthplace: Rockville, Montg. Co. Maryland

16. Informant: Mr. Lloyd W. Howes
Address: West End Park, Rockville, Md.

17. Burial
(Burial, cremation, or removal. Which?)
Date thereof: Aug. 18, 1946 (month) (day) (year)

Cemetery or crematory: Rockville Union Cem.

Location: Rockville, Maryland

18. Funeral director: W. Reuben Pumphrey
Address: Rockville, Maryland

19. 8-19 19 46 Betty Jane Snyder
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Aug 16 19 46, at 9:00 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from
Dec 1 Med Exam 19 ..... to ..... 19 .....
and that I last saw h..... alive on Aug 16 19 .....

Immediate cause of death	DURATION
Coronary occlusion	about 4 months
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....

Autopsy results: .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: ..... Date of .....
Where did injury occur? ..... (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) .....
Means of injury ..... Injured at work?

23. SIGNATURE: Frank J. Burchard M.D.
Dep. Med. Exam
M. D. or other
Address: Gaithersburg Md Date signed: 8-16-46

Evidence for change of year of birth of deceased is shown on

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (21)

★ 08175

FILM No. I 07 SEP 13 1946

CERTIFICATE OF DEATH

Reg. Diat. No. 216

1. PLACE OF DEATH:
County MONTGOMERY
City or town CHEVY CHASE
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, Institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State MD County MONTGOMERY
City or town CHEVY CHASE
(If outside city or town limits, write RURAL and give nearest town)
Street No. 6604 HILLANDALE, RD.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME MRS. CECILIA JOHNSTON

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	W	W

6.(b) Name of husband or wife JOHN FRANKLIN

7. Birth date of deceased (mo., day, yr.) DEC 25 1858

8.(c) If alive, give age 87 years

8. AGE:

Years	Months	Days	If less than one day
87			....hrs. ....min.

9. Birthplace IOWA CITY, IOWA
(Town, county, and state)

10. Usual occupation HOUSEWIFE

11. Industry or business

FATHER
12. Name JOHN J. LACK
13. Birthplace GERMANY

MOTHER
14. Maiden name M. LOUISE KINZELL
15. Birthplace GERMANY

16. Informant MRS. JEAN HASTINGS
Address 6604 HILLANDALE RD.

17. BURIAL (Burial, cremation, or removal. Which?) Date thereof 9-2-46 (month) (day) (year)
Cemetery or crematory NISKY HILL
Location BETHLEHEM, PENN.

18. Funeral director JOS. GAWLER'S SONS
Address 1756 Pa. AVE N.W.

19. 8/31 1946 (Date rec'd by registrar) Wm E Jones Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH August 30 1946, at 6:05 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Feb 7 1943, to Aug. 30 1946 and that I last saw h.Cx. alive on Aug. 28 1946

Immediate cause of death	DURATION
Congestive Heart Failure.	1 Wk.
Due to Cardio-Vascular Renal Disease	3 Yrs.
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations Date of op.

Autopsy results.
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE Harold Keyser M.D.
M. D. or other
Address [illegible] Date signed 8/30/46

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-1

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 47 (c)

08176

CERTIFICATE OF DEATH

Reg. Dist. No. 223

1. PLACE OF DEATH:

County: Montgomery

City or town: Takoma Park, Md.

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred: Wash San. and Hosp

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: D.C. County:

City or town: Washington

(If outside city or town limits, write RURAL and give nearest town)

Street No. 5315 - 42nd ST. N.W.

(If rural, give LOCATION)

2.(a) If veteran, name war:

3.(a) FULL NAME: Johnston, Mrs. Cora E.

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Married.

6.(b) Name of husband or wife: Mr John W. Johnston

6.(c) If alive, give age: 69 years

7. Birth date of deceased (mo., day, yr.): July 3 1880

8. AGE: Years	Months	Days	If less than one day: hrs.	min.
66	1	16		

9. Birthplace: Buffalo, N York (Town, county, and state)

10. Usual occupation: house wife.

11. Industry or business

FATHER — 12. Name: Edward Shaw

13. Birthplace: Buffalo New York

MOTHER — 14. Maiden name: Imogene Hibbard

15. Birthplace: Palmyra - New York

16. Informant: Sanitarium Records.

Address

17. Burial (Burial, cremation, or removal. Which?) Date thereof August 20 1946 (month) (day) (year)

Cemetery or crematory: Glenwood

Location: Lockport New York

18. Funeral director: L.A. Hines Co.

Address: 2901 - 14 St N.W. Washington D.C.

19. Aug 19 1946 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: August 19 1946 at 7 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 28 1946 to Aug 19 1946 and that I last saw h_ alive on Aug. 18,1 1946

Immediate cause of death	DURATION
Bronchogenic Carcinoma	2
With Generalized metastasis	months
Due to Arteriosclerosis	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.

Autopsy results: Are above

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: Wm Vork Meade M.D. or other

Address: 504 Tulip Ave. Takoma Park, Md. Date signed: 8-19-46

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Use correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (32)

CERTIFICATE OF DEATH

08177

★ Reg. Diat. No. 223

1. PLACE OF DEATH:

County: Montgomery

City or town: Takoma Park

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 10 minutes

Hospital, Institution, or street address where death occurred:

Washington Sanitarium and Hospital

How long in hospital or institution? 10 minutes

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: D.C. County:

City or town: Washington

(If outside city or town limits, write RURAL and give nearest town)

Street No. 109 Rittenhouse st. N.W.

(If rural, give LOCATION)

2.(a) If veteran, name war: ✓

3.(a) FULL NAME: Mr. Thomas Owen Jones

3.(b) Social Security Number: 195-07-7274

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	Cauc.	Married

6.(b) Name of husband or wife: Mrs. Josephine M. Jones

7. Birth date of deceased (mo., day, yr.): August 1, 1904 6.(c) If alive, give age: years

8. AGE: Years	Months	Days	If less than one day: hrs.	min.
42	0	0		

9. Birthplace: Whitaker Pennsylvania (Town, county, and state)

10. Usual occupation: Accountant and Salesman

11. Industry or business:

FATHER 12. Name: Thomas Owen Jones Sr.

13. Birthplace: Pennsylvania

MOTHER 14. Maiden name: Mabel M. King

15. Birthplace: McKeesport, Pennsylvania

16. Informant: Mrs. Josephine Jones

Address: 109 Rittenhouse St. N.W.

17. REMOVAL + BURIAL (Burial, cremation, or removal. Which?) Date thereof: Aug 5 1946 (month) (day) (year)

Cemetery or ~~crematory~~: EAST HARRISBURG

Location: HARRISBURG - DAUPHIN Co - Pa.

18. Funeral director: Warner E. Pumphrey

Address: SILVER SPRING - Md.

19. Aug 2 1946 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: August 1 1946 at 1:15 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ..... 19.. to ..... 19..

and that I last saw h. alive on August 1 1946

Immediate cause of death	DURATION
Sudden Death - Hypertensive Heart Disease	
Due to: Hypertension (1	Unknown
Due to: Hypertrophy of Heart	unknown
Other conditions: Pulmonary edema	1 hour +

(Include pregnancy within 3 months of death)

Major findings of operations: —

Date of op.

Autopsy results: as above

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: Warren G. Bennett Capt MC at authorization of F.J. Gaudy M.D. or other Coroner

Address: Armed Institute of Pathology Date signed: Aug 1, 1946.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (13-a)

08178

CERTIFICATE OF DEATH

Reg. Diat. No. 316

1. PLACE OF DEATH:

County: Montgomery

City or town: Bethesda

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, Institution, or street address where death occurred: Suburban Hospital

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Montgomery

City or town: Rockville

(If outside city or town limits, write RURAL and give nearest town)

Street No.: Rural Route 2

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME: Henry J. Joppy

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	Negro	Married

6.(b) Name of husband or wife: Mildred Joppy

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): July 4, 1892

8. AGE:

Years	Months	Days	If less than one day
54	1	4	..... hrs. ..... min.

9. Birthplace: Maryland (Town, county, and state)

10. Usual occupation: laborer

11. Industry or business

FATHER — 12. Name: Amos Joppy

13. Birthplace: Maryland

MOTHER — 14. Maiden name: Susie Lowes

15. Birthplace: Maryland

16. Informant: Dep. Records

Address

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Aug. 10, 1946 (month) (day) (year)

Cemetery or crematory: Lincoln Park Cem

Locatio: Rockville, Md

18. Funer director: R. L. Snowden

Address: Rockville, Md.

19. 8/10/1946 (Date rec'd by registrar) Jno E Dodson Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 8-7-46 19.46 at 12:30 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 29 19.46, to August 7 19.46 and that I last saw h. (it) alive on August 6 19.46

Immediate cause of death	DURATION
HYPERTENSIVE CARDIO-RENAL DISEASE	several years
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE: Dewitt E. DeSantis M.D. M. D. or other

Address: Suburban Hosp Bethesda Md. Date signed: 7 August 1946

VS A15 9-45-1

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (467)

CERTIFICATE OF DEATH

Reg. Dist. No. 0817 Ser. 4

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

1. PLACE OF DEATH:
County: Montgomery
City or town: Fairland
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
R. F. D. 2 Silver Spring
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Montgomery
City or town: Fairland
(If outside city or town limits, write RURAL and give nearest town)
Street No.: R. F. D. #2, Silver Spring, Md.
(If rural, give LOCATION)
2.(a) If veteran, name war: - - -

3. (a) FULL NAME: ROSENDO ANTHRIDGE KINCAID

3. (b) Social Security Number: 223-24-4377

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	white	Widowed

6.(b) Name of husband or wife: Gertrude Cornelia
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): May 29th. 1873

8. AGE: Years	Months	Days	If less than one day
73	2	3	hrs. min.

9. Birthplace: Williamsville, Va.
(Town, county, and state)
10. Usual occupation: Farmer
11. Industry or business
FATHER 12. Name: Hamilton H. Kincaid
13. Birthplace: Virginia
MOTHER 14. Maiden name: Harriet J. Rogers
15. Birthplace: Virginia
16. Informant: William H. Kincaid
Address: Fairland, Maryland
17. Burial (Burial, cremation, or removal. Which?) Date thereof: Aug. 4, 1946 (month) (day) (year)
Cemetery or crematory: Lyle Chapel Cemetery
Location: Millboro, Bath County, Virginia
18. Funeral director: Wm. E. Pumphrey
Address: Silver Spring, Maryland
19 Aug 3 1946 (Date rec'd by registrar) Josephine M. Schaffer Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Aug 2. 1946 at 12:45 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 7/26 1946, to Aug 2 1946
and that I last saw h alive on Aug 1 1946

Immediate cause of death	DURATION
Pulmonary edema	7
	1
Due to Carcinoma Lung	
Lung Cancer	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: [signature] M. D. or Coroner
Address: Rockville Date signed: 8/3/46

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (46-2)

CERTIFICATE OF DEATH

08180

Reg. Dist. No. 216

1. PLACE OF DEATH:

County: Montgomery

City or town: Bethesda (rural)
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 17 days

Hospital, institution, or street address where death occurred:
U.S. Naval Hospital, Bethesda, Md.

How long in hospital or institution? 17 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: ..... County: .....

City or town: Washington, D.C.
(If outside city or town limits, write RURAL and give nearest town)

Street No. 1311 3rd St. N.W. Wash, DC.
(If rural, give LOCATION)

2.(a) If veteran, name war: World War I ✓

3.(a) FULL NAME

Cornelius Alexander KING V.B.P.

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	negro	married

6.(b) Name of husband or wife: Mrs. Harriete King

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): March 4, 1881

8. AGE: Years	Months	Days	If less than one day
65	5	1	..... hrs. ..... min.

9. Birthplace: Maryland
(Town, county, and state)

10. Usual occupation: Veteran

11. Industry or business

FATHER
12. Name: George King (dec)
13. Birthplace: Md.

MOTHER
14. Maiden name: Amelia Hill (dec)
15. Birthplace: Md.

16. Informant: Mrs. Harriete King
Address: 1311 3rd St. N.W. Wash., D.C.

17. burial — Date thereof: 8-8-46
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory: Arlington National

Location: Arlington, Va.

18. Funeral director: Mc Guire Funeral Service (W. H.)
Address: 1820 9th St. N.W. Wash., D.C.

19. 5 August 1946 — Mary Charlotte Smith, Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH: 5 August 1946, at 9:50 a.m.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 18 1946, to 5 Aug. 1946 and that I last saw him alive on 5 Aug 1946.

	DURATION
Immediate cause of death: Generalized Peritonitis and Bronchopneumonia	1 month
Due to: Carcinoma of Cecum with perforation into abdominal cavity	1 year
Due to:	
Other conditions: Cardiac Hypertrophy Generalized Arteriosclerosis (Include pregnancy within 3 months of death)	several years.

Major findings of operations: ..... Date of op. .....

Autopsy results: Same as above.

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE: Roald N. Grant
R. N. GRANT, Cdr, (MC) USN
M. D. or other

Address: USNH Bethesda, Md. Date signed: 8-5-46

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

SVS A15 9-45-15

8/9/46

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (33a)

CERTIFICATE OF DEATH

08181

Reg. Dist. No. 216

1. PLACE OF DEATH:

County: Montgomery

City or town: Bethesda (rural)
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 14 da ys

Hospital, Institution, or street address where death occurred:
U. S. NAVAL HOSPITAL, BETHESDA, MD.

How long in hospital or institution? 14 Days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: County:

City or town: Washington, D.C.
(If outside city or town limits, write RURAL and give nearest town)

Street No. 4201 9th St., NW., Wash., D.C.
(If rural, give LOCATION)

2.(a) If veteran, name war: World War I

3. (a) FULL NAME: KITCHEN, John Henry VAP

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	W-US	Married

6.(b) Name of husband or wife: Mary A. Kitchen

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): 23 August 1889

8. AGE: Years	Months	Days	If less than one day
56	11	16	hrs. min.

9. Birthplace: Virginia
(Town, county, and state)

10. Usual occupation: Carpenter

11. Industry or business:

FATHER
12. Name: William W. Kitchen
13. Birthplace:

MOTHER
14. Maiden name: Mary V. Waple
15. Birthplace: Virginia

16. Informant: Wife: Mary A. Kitchen
Address: 4201 9th St. NW, Wash., D.C.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Aug. 13, 1946 (month) (day) (year)

Cemetery or crematory: Arlington National Cemetery

Location: Arlington Virginia

18. Funeral director: W.W. Chambers

Address: 1400 Chapin St., NW., Wash., D.C.

19. 10 August 1946 (Date rec'd by registrar)

Mary Charlotte Smith
Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 9 August 1946, at 6:10 p.m.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 26 July 1946 to 9 aug. 1946 and that I last saw him alive on 9 august 1946

Immediate cause of death	DURATION
Cerebral hemorrhage	1 wk
Due to: hypertension	years
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operation: Date of op.:

Autopsy results: Cerebral hemorrhage

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, Industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: Charles W. Thompson M.D. M. D. or other

Address: Naval Hospital, Bethesda, Md. Date signed: 12 Aug '46

VS A15 9-45-15

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

STATE OF MARYLAND—CERTIFICATE OF DEATH 08182

V. S. No. 1

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH

County Montgomery — Registration Dist. No. 214

Village or City Silver Spring — No. 9201 Colesville Rd St., Ward

(If death occurred in a hospital or institution, give its NAME instead of street and number)

Length of residence in city or town where death occurred 16 yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

2. FULL NAME Harvey Wilson Kreyling — If U. S. Veteran, specify WAR

(a) Residence: No. 424 Windsor Rd. St., Ward.

(Usual place of abode) — If nonresident give city or town and State

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word)
M	W	Married

5e. If married, widowed, or divorced HUSBAND of ~~(or) WIFE of~~ Oliver Blanche Kreyling

6. DATE OF BIRTH (month, day, end year) Nov 14, 1871

7. AGE	Years	Months	Days	If LESS then 1 day, hrs. or min.
	74	2	10	

OCCUPATION

8. Trade, profession, or particular kind of work done, as SPINNER, SAWYER, BOOKKEEPER, etc. retired

9. Industry or business in which work was done, as SILK MILL, SAW MILL, BANK, etc.

10. Date deceased last worked at this occupation (month and year)

11. Total time (years) spent in this occupation

12. BIRTHPLACE (city or town) Findlay
(State or country) Ohio

FATHER

13. NAME Wm Kreyling

14. BIRTHPLACE (city or town)
(State or country) Germany

MOTHER

15. MAIDEN NAME Frenz Harvey

16. BIRTHPLACE (city or town) Findlay
(State or country) Ohio

17. INFORMANT Mrs Oliver B Kreyling
(Address) 9201 Colesville Rd

18. BURIAL, ~~CREMATION, OR REMOVAL~~
Place Spring Grove Cem. Cincinnati, Ohio Date August 25, 1946

19. UNDERTAKER Harry L. Sluyter
(Address) 1009-11 H Street, N.W.

20. FILED Aug 24, 1946 Josephine M Schaeffe
Registrar

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH August (Month) 24 (Dey), 1946 (Yeer)

22. I HEREBY CERTIFY, That I attended deceased from January, 1940, to August 24, 1946

I last saw him alive on Aug 24, 1946; death is said to have occurred on the date stated above, at 11:30 A.m.

The PRINCIPAL CAUSE OF DEATH and relatad causes of importance were es follows:

	Date of onset
Coronary occlusion	5 mn.
Other Contributary Causes of importance: Generalyzed Arteriosclerosis	8 yrs.

Neme of operetion — Dete of

What test confirmed diegnosis? — Wes there en autopsy?

23. If death wes due to external causes (VIOLENCE) fill in also the following:

Accident, suicide, or homicide? — Date of injury , 19

Where did injury occur? (Specify city or town, county and State)

Specify whether injury occurred in INDUSTRY, in HDME, or in PUBLIC PLACE.

Menner of Injury

Nature of injury

24. Was diseese or injury in eny way related to occupation of deceased?

If so, specify

(Signed) W B Wardrop M. D.

(Address) 943 Bonifant St.

If more blanks are needed, address State Registrar, 2411 N. Charles Street, Baltimore, Requesting U. S. No. 1 Delive Spring Mfg.

UNITED STATES STANDARD CERTIFICATE OF DEATH

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. Make some entry in this section for every person aged 10 years or over. If the deceased had retired from business, report the occupation prior to retirement. Children not gainfully employed may be returned as at school or at home. For a woman whose only occupation was that of home housework, write housewife in answer to Question 8 and own home in answer to Question 9. For a person engaged in domestic service for wages, however, designate the occupation by the appropriate terms, as servant—private family, cook—hotel, etc. For a person who had no occupation whatever write none.

To be complete, an occupation return must state:

8.—The trade, profession, or particular kind of work done.
9.—The industry or business in which the work was done.
10.—The month and year the deceased last worked at the occupation.
11.—The number of years the deceased followed the occupation.

In stating the occupation, avoid the use of such indefinite terms as "employee," "worker," "operative," etc. Find out the particular kind of work done and return that, as spinner, weaver, etc.

In stating the industry or business, avoid the use of such general terms as "store," "factory," "mill," etc. State the particular kind of store, factory, mill, etc., as grocery store, soap factory, cotton mill, etc.

Distinguish carefully the different kinds of engineers by stating the full descriptive titles, as civil engineer, mechanical engineer, mining engineer, stationary engineer, etc. Avoid the term "laborer" when a more precise statement of the occupation can be secured. Do not use the word "mechanic," but give the exact occupation, as carpenter, painter, machinist, etc. Distinguish carefully between retail merchants and wholesale merchants. A person who sells goods should be called a salesman and not a clerk.

Statement of cause of death.—Cause of death means the disease, injury, or complication which causes death, not the mode of dying, e. g., heart failure, asphyxia, asthenia, etc. As principal cause name the disease or injury causing death. As related causes, name earlier morbid conditions, if any, related to the principal cause and any important complication of the principal cause. Under other contributory causes of importance, name other important diseases or injuries. Examples:

Example I

The principal cause of death and related causes of importance were as follows:	Date of onset
Arteriosclerosis	*1915*
Chronic interstitial nephritis	*1921*
Cerebral hemorrhage	*July 5, 1927*
Other contributory causes of importance:	
Gallstones	*May 1, 1923*

Example II

The principal cause of death and related causes of importance were as follows:	Date of onset
Attack of epilepsy	*1 week ago*
Run over by street car	*1 week ago*
Peritonitis	*3 days ago*
Other contributory causes of importance:	
Gastroenteritis	*1 year*

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

08183

Reg. Dist. No. 216

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

County Montgomery

City or town Bethesda Md.
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? since 7-7-'46

Hospital, institution, or street address where death occurred: Suburban Hospital

How long in hospital or institution? since 7-7-'46

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Maryland County Montgomery

City or town Rockville
(If outside city or town limits, write RURAL and give nearest town)

Street No. R.R. #1
(If rural, give LOCATION)

2.(a) If veteran, name war NONE

3.(a) FULL NAME Elijah Lizear

3.(b) Social Security Number 217-16-7278

4. Sex M

5. Color or race W

6.(a) Single, married, widowed, or divorced

6.(b) Name of husband or wife Beulah - (deceased)

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) February 13, 1882

8. AGE: Years 64 Months 5 Days 20 If less than one day — hrs. — min.

9. Birthplace RedLand, Maryland
(Town, county, and state)

10. Usual occupation Laborer

11. Industry or business

FATHER

12. Name Sammuel J. Lizear

13. Birthplace MARYLAND

MOTHER

14. Maiden name Unknown Beach

15. Birthplace Maryland

16. Informant Mrs. Laura L. Edwards (daughter)

Address Gaithersburg - Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof Aug. 6, 1946 (month) (day) (year)

Cemetery ~~or crematory~~ Forest Oak Cemetery

Location Gaithersburg - Md.

18. Funeral director WM. Reuben Pumphrey

Address Bethesda 14, Maryland

19. 8/5 1946 (Date rec'd by registrar) Wm E Jobes Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 8-3- 1946, at 12:15 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 1946, to Aug 3 1946 and that I last saw h im alive on Aug 3 19

Immediate cause of death Toxemia

Due to Typhoid Fever — DURATION: 1 mo

Due to

Other conditions
(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE [illegible signature] M. D. or other

Address 8016 [illegible] Date signed 8/3/46

VS A15 9-45-1

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

08184

CERTIFICATE OF DEATH

Reg. Dist. No. 216

1. PLACE OF DEATH:

County: Montgomery County

City or town: Chevy Chase (6 Quincy Street)

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 20 Years

Hospital, institution, or street address where death occurred: ----

How long in hospital or institution? ----

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Montgomery

City or town: Chevy Chase

(If outside city or town limits, write RURAL and give nearest town)

Street No. 6 Quincy Street

(If rural, give LOCATION)

2.(a) If veteran, name war: ----

3. (a) FULL NAME: JOHANNA MARGUERITE LOHSE

3. (b) Social Security Number: ----

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Single

6.(b) Name of husband or wife: single

6.(c) If alive, give age: ..... years

7. Birth date of deceased (mo., day, yr.): June 27,1898

8. AGE:

Years	Months	Days	If less than one day
48	2	0	..... hrs. ..... min.

9. Birthplace: Liege, Belgium (Town, county, and state)

10. Usual occupation: Governess and Teacher

11. Industry or business:

FATHER

12. Name: Karl Lohse

13. Birthplace: Aurbach, Saxonia, Germany

MOTHER

14. Maiden name: Marguerite Neubaueer

15. Birthplace: Neustettin, Pomerania, Germany

16. Informant: Mrs. Marguerite N. Lohse

Address: 6 - Quincy Street, Chevy Chase, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: August 30, 1946 (month) (day) (year)

Cemetery or crematory: Fort Lincoln Cemetery

Location: Prince Georges County, Md.

18. Funeral director: Martin W. Hysong Co.

Address: 1300 - N Street N.W. Wash. D.C.

19. 8/28 1946 (Date rec'd by registrar) Wm E Jobes Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: August 27 1946, at 9 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sept. 5 1945, to Aug. 27 1946, and that I last saw her alive on Aug. 27 1946

Immediate cause of death: Cerebral Hemorrhage

Due to: Unknown

Due to: Unknown

Other conditions: None

(Include pregnancy within 3 months of death)

Major findings of operations: None

Date of op. .....

Autopsy results: None

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE: Bernard L. French M. D. or other

Address: 2017 R St. N.W. Wash. D.C. Date signed: 8-27-46

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (92nd)

08185

CERTIFICATE OF DEATH

Reg. Dist. No. 216

1. PLACE OF DEATH:

County: Montgomery

City or town: Cabin John

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 37 yrs

Hospital, Institution, or street address where death occurred: Bethesda R.F.D.

How long in hospital or institution? —

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Montg

City or town: Cabin John

(If outside city or town limits, write RURAL and give nearest town)

Street No. Bethesda R.F.D.

(If rural, give LOCATION)

2.(a) If veteran, name war: —

3.(a) FULL NAME: Walter Mason

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	Col	married

6.(b) Name of husband or wife: Sarah C. Mason

6.(c) If alive, give age: 57 years

7. Birth date of deceased (mo., day, yr.): July 29 1890

8. AGE:

Years	Months	Days	If less than one day
56	0	12	...hrs. ...min.

9. Birthplace: Potomac, Monty Co Md (Town, county, and state)

10. Usual occupation: laborer

11. Industry or business: —

FATHER

12. Name: Noah Mason

13. Birthplace: Monty Co, Md

MOTHER

14. Maiden name: Jemima Brooks

15. Birthplace: Monty. Co. Md

16. Informant: Sarah Mason

Address: Bethesda Md R.F.D.

17. Removal (Burial, cremation, or removal. Which?) Date thereof 8/11/46 (month) (day) (year)

Cemetery or crematory:

Location: Washington, D.C.

18. Funeral director: W. Ernest Garvin Co.

Address: 1432 You. Ave. N.W. Washington D.C.

19. 8/11 1946 (Date rec'd by registrar) Wm E Jobes Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Aug 11 1946, at 5:50 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dec 3rd 1945 to ... 19... and that I last saw h... alive on ... 19...

	DURATION
Immediate cause of death: Acute myocarditis	5 hrs
Due to: chronic Valvular heart	
Due to: disease	7 mo
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations: ... Date of op. ...

Autopsy results: ...

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ... Date of ...

Where did injury occur? ... (City or town) (County) (State)

Injured at home, farm, Industry, public place (where?) ...

Means of injury ... Injured at work?

23. SIGNATURE: Frank J. Brockard M.D. M. D. or other

Address: Gaithersburg Md Date signed 8-11-46

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 18

08186

CERTIFICATE OF DEATH

Reg. Dist. No. 21 8

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County: Montg. Co.

City or town: Gaithersburg, (Rural)
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 3 yrs

Hospital, institution, or street address where death occurred:
11 Da,

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Montgomery

City or town: Gaithersburg (Rural)
(If outside city or town limits, write RURAL and give nearest town)

Street No.
(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME: Sophia Elizabeth McCain

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Married

6.(b) Name of husband or wife: Henry Edward McCain

6.(c) If alive, give age: 55 years

7. Birth date of deceased (mo., day, yr.): Aug 4th 1893

8. AGE: Years	Months	Days	If less than one day
1893 53	0	20	...hrs. ...min.

9. Birthplace: Kittanning Pa,
(Town, county, and state)

10. Usual occupation: House Wife

11. Industry or business:

FATHER
12. Name: Joseph Lynds
13. Birthplace: Pa,

MOTHER
14. Maiden name: Bertha Surkoski
15. Birthplace: Pa.

16. Informant: Joseph Nealer
Address: Gaithersburg. Md,

17. Burial (Burial, cremation, or removal. Which?) Date thereof 8/27/46 (month) (day) (year)

Cemetery or crematory: Kittanning Cemetery
Location: Kittanning Pa,

18. Funeral director: Ernest C Gartner
Address: Gaithersburg. Md,

19. Aug 24 1946 (Date rec'd by registrar) Alvida L Cooke Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 24 Aug 1946, at 9:15 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 1946, to 24 Aug 1946 and that I last saw h.. alive on 23 Aug 1946

	DURATION
Immediate cause of death: Cachexia	4 Mons
Due to: Carcinoma of Stomach	6 Mons
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations: exploratory
Date of op. June 46

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: W S Murphy MD
M. D. or other

Address: Rockville Md Date signed 24 Aug 46

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (94a)

CERTIFICATE OF DEATH

08187

Reg. Diat. No. 223

1. PLACE OF DEATH:

County: Montgomery

City or town: Takoma Park

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 12 yrs

Hospital, Institution, or street address where death occurred:

6/0 Carroll Ave

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Montgomery

City or town: Takoma Park

(If outside city or town limits, write RURAL and give nearest town)

Street No. 6/0 Carroll Ave

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME: Nellie W. McChesney

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	white	married

B.(b) Name of husband or wife: J. W. McChesney

6.(c) If alive, give age: 66 years

7. Birth date of deceased (mo., day, yr.): Sept 5 1881

8. AGE:

Years	Months	Days	If less than one day
64	11	10	..... hrs. ..... min.

9. Birthplace: Washington D.C. (Town, county, and state)

10. Usual occupation: Saleswoman

11. Industry or business: -

FATHER

12. Name: Chas E. Green

13. Birthplace: Maryland

MOTHER

14. Maiden name: Sarah Webster

15. Birthplace: Maryland

16. Informant: J. W. McChesney

Address: 6/0 Carroll Ave. Takoma Pk.

17. Burial (Burial, cremation, or removal? Which?) Date thereof: Aug 17 1946 (month) (day) (year)

Cemetery or crematory: Glenwood Cem.

Location

18. Funeral director: J. H. Hines Co.

Address: 2901 14th St. N.W.

19. Aug 16 1946 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Aug 15 1946, at 8:45 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sept 1945 to 19..., and that I last saw h... alive on Aug 15 1946

Immediate cause of death	DURATION
Coronary occlusion	Died suddenly
Due to	
Due to	
Other conditions: Hypertension	6 mo.

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: Frank J. Brockhart M.D. M. D. or other

Address: Gaithersburg Md. Date signed: 8-16-46

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (49-a)

CERTIFICATE OF DEATH

08188

Reg. Dist. No. 216

1. PLACE OF DEATH:

County Montgomery

City or town Bethesda (If outside city or town limits, write RURAL and give nearest town) Md.

How long in above place of death? since 5-25-1946

Hospital, Institution, or street address where death occurred: Suburban Hosp. 8600 Old Georgetown Rd

How long in hospital or institution? Since 5-25-46 Bethesda, Md.

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State Maryland County St. Marys

City or town Lexington Pk. Md. (If outside city or town limits, write RURAL and give nearest town)

Street No. 46 Coral Place (If rural, give LOCATION)

12. (a) If veteran, name war

3. (a) FULL NAME Mrs Mary McKee

3. (b) Social Security Number

4. Sex	5. Color or race	6. (a) Single, married, widowed, or divorced
F	White	

6. (b) Name of husband or wife Theodore McKee

6. (c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) January 13, 1909

8. AGE: Years	Months	Days	If less than one day
37	7	1	..... hrs. ..... min.

9. Birthplace Nashville, Tenn. (Town, county, and state)

10. Usual occupation Housewife

11. Industry or business

FATHER 12. Name Phillip Farrell

13. Birthplace Nashville Tenn.

MOTHER 14. Maiden name Mary Wilkie

15. Birthplace McCewen, Tenn.

16. Informant Theodore McKee.

Address Lexington Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Aug 17-1946 (month) (day) (year)

Cemetery or crematory Fort Lincoln Cemetery

Location 3201 - Bladensburg Rd. Md.

18. Funeral director Wm. J. Malley

Address 3200 - R. I. Ave. Mt. Rainier, Md.

19. 8/14 1946 Mr E Jones (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 8-14-46 1946 at 1 P. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 25 1946 to August 14 1946 and that I last saw h.e.r alive on August 14 1946

	DURATION
Immediate cause of death Generalized carcinomatosis	12 months
Empyema	
Due to Carcinoma of ovary	
Due to	
Other conditions None	

(Include pregnancy within 3 months of death)

Major findings of operations Generalized carcinoma Empyema Date of op. 7/22/1946

Autopsy results Generalized carcinomatosis

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of Injury ..... Injured at work?

23. SIGNATURE Barbara Moulton M.D. M. D. or other

Address Suburban Hospital Bethesda Md. Date signed 8/19/46

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15

8012

DAY: letter from USN hosp
filmed 9-3-46 LL

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (07)

CERTIFICATE OF DEATH

08189

Reg. Dist. No. 716

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH:
County: Montgomery
City or town: Bethesda (Rural)
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 1 month 7 days
Hospital, Institution, or street address where death occurred:
U.S. NAVAL HOSPITAL BETHESDA, MD.
How long in hospital or institution? 1 MONTH 7 DAYS.

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: County:
City or town: Washington, D.C.
(If outside city or town limits, write RURAL and give nearest town)
Street No. 4342 Livingston Rd.SE, Wash.,D.C.
(If rural, give LOCATION)
2.(a) If veteran, name war: World War I.

3. (a) FULL NAME
MC KEEVER, William (n) VAP

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	W-US	Married

6.(b) Name of husband or wife: Mrs. Sally McKeever
6.(c) If alive, give age: 53 years

7. Birth date of deceased (mo., day, yr.): 12-19-94

8. AGE: Years	Months	Days	If less than one day
51	8	27	...hrs. ...min.

9. Birthplace: Virginia (Town, county, and state)
10. Usual occupation: Veteran
11. Industry or business
FATHER 12. Name: William McKeever
FATHER 13. Birthplace: Virginia
MOTHER 14. Maiden name: Annie Bryant
MOTHER 15. Birthplace: Virginia
16. Informant: Mrs. Sally McKeever
Address: 4342 Livingston Rd.SE, Wash., D.C.
17. Burial (Burial, cremation, or removal. Which?) Date thereof: Aug. 20, 1946 (month) (day) (year)
Cemetery or crematory: Arlington National
Location: Arlington, Virginia.
18. Funeral director: W. W. CHAMBERS
Address: 1400 Chapin St., NW., Wash., D.C.
19. ...19... (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: August 16 1946, at 1518 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from August 12 1946 to August 16 1946 and that I last saw him alive on August 16 1946

Immediate cause of death	DURATION
Broncho pneumonia	unkn.
Due to	
Due to	
Other conditions: Chronic Rheumatoid Arthritis	20 yrs

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.
Autopsy results: Broncho pneumonia
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: Thomas N. Dalton M.D. (M. D. or other)
Address: USNH. Bethesda Md. Date signed: 20 Aug 1946

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

08190

Reg. Dist. No. 216

1. PLACE OF DEATH:

County Montgomery

City or town Bethesda, Maryland

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 1 Month

Hospital, institution, or street address where death occurred:

4808 Battery Lane,

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Montgomery

City or town Bethesda, Maryland

(If outside city or town limits, write RURAL and give nearest town)

Street No. 4808 Battery Lane,

(If rural, give LOCATION)

2.(a) If veteran, name war No

3.(a) FULL NAME Mary E. ~~Mitche~~ Mitchell

3.(b) Social Security Number

4. Sex Female

5. Color or race White

6.(a) Single, married, widowed, or divorced Married

6.(b) Name of husband or wife Herbert F. Mitchell

6.(c) If alive, give age 61 years

7. Birth date of deceased (mo., day, yr.) March 19 - 1905

8. AGE: Years	Months	Days	If less than one day
41	10	5	hrs. min.

9. Birthplace Culpepper Co. Va.
(Town, county, and state)

10. Usual occupation Clerk- Parkside Drug Store

11. Industry or business Drug Store

FATHER

12. Name Geo. Easthan

13. Birthplace Culpepper Co. Va.

MOTHER

14. Maiden name Jennie Rixey

15. Birthplace Culpepper Co. Va.

16. Informant Mr. Joseph S. Pigford

Address 4808 Battery Lane, Bethesda, Md.

17. Burial Date thereof 8/31/46
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Fairview, Culpepper, Va.

Location Same

18. Funeral director W. W. Chambers Co.

Address Washington D.C.

19. 8/29 1946 Wm E Jobes Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug 29 1946, at 8:15 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dep med Exam case 19 to 19

and that I last saw h alive on 19

Immediate cause of death	DURATION
Cerebral hemorrhage	1/2 hr.
Due to	
Due to	
Other conditions Hypertension	1 yr.

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Frank J. Broschart Dep med. Exam
M. D. or other

Address Gaithersburg md Date signed 8-29-46

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (88-a)

08191

CERTIFICATE OF DEATH

★ Reg. Dist. No. 216

1. PLACE OF DEATH:
County: Montgomery
City or town: Bethesda (rural)
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? six days
Hospital, institution, or street address where death occurred:
US Naval Hospital, Bethesda, Md.
How long in hospital or institution? six days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Va. County: Arlington
City or town: Arlington
(If outside city or town limits, write RURAL and give nearest town)
Street No. 6040 20th St., N.
(If rural, give LOCATION)
2.(a) If veteran, name war: ✗ ✓

3.(a) FULL NAME: NAEFE, Paul Richard

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	W-US	married

6.(b) Name of husband or wife: Mrs. Bessie Naefe
6.(c) If alive, give age: ..... years

7. Birth date of deceased (mo., day, yr.): April 11, 1896

8. AGE: Years	Months	Days	If less than one day
50	4	18	..... hrs. ..... min.

9. Birthplace: Mo. (Town, county, and state)
10. Usual occupation: veteran
11. Industry or business:

FATHER
12. Name: Albin Naefe
13. Birthplace: Germany (dec)

MOTHER
14. Maiden name: Rosa Michler
15. Birthplace: Switzerland

16. Informant: wife: Mrs. Bessie Naefe
Address: 6040 20th Street, N. Arlington, Va.

17. burial (Burial, cremation, or removal. Which?) Date thereof: 8-31-46 (month) (day) (year)
Cemetery or crematory: Arlington National
Location: Arlington, Va.

18. Funeral director: W. W. CHAMBERS
Address: 1400 Chapin St., N. W., Wash., D. C.

19. 8-29- 46 (Date rec'd by registrar) Mary Charlotte Smith Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 29 August 1946 at 4:34 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 23 August 1946 to 29 August 1946 and that I last saw him alive on 29 Aug. 1946

Immediate cause of death	DURATION
Cerebral Hemorrh.	9 days
Due to: Hypertension	? years
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....
Autopsy results: Cerebral hemorrhage
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: ..... Date of .....
Where did injury occur? ..... (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) .....
Means of injury ..... Injured at work?

23. SIGNATURE: C. W. THOMPSON, Lt. Comdr. (MC) USNR
Address: USNH Bethesda, Md. M. D. or other
Date signed: 8-29-46

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

9/5/46

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (74a)

CERTIFICATE OF DEATH

08192

Reg. Dist. No. 216

1. PLACE OF DEATH:

County: Montgomery

City or town: Bethesda (Rural)
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 1 month 5 days

Hospital, Institution, or street address where death occurred:
U.S. Naval Hospital, Bethesda, Md.

How long in hospital or institution? 1 month 5 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Md. County: Balto.

City or town: Halethorpe, Maryland.
(If outside city or town limits, write RURAL and give nearest town)

Street No. 4113 Wash. Blvd, Halethorpe Md.
(If rural, give LOCATION)

2.(a) If veteran, name war: World War II

3.(a) FULL NAME: NEAT, George Robert Flc, USN.

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	W-US	Single

6.(b) Name of husband or wife: Mother

6.(c) If alive, give age: 49 years

7. Birth date of deceased (mo., day, yr.): 12-13-26

8. AGE: Years	Months	Days	If less than one day
19	8	7	..... hrs. ..... min.

9. Birthplace: Maryland
(Town, county, and state)

10. Usual occupation: U.S. Navy

11. Industry or business:

FATHER
12. Name: Percy (n) Neat
13. Birthplace: Maryland

MOTHER
14. Maiden name: Freber Tshauser
15. Birthplace: Maryland.

16. Informant: Mother
Address: 4113 Washington Blvd., Halethorpe, Md.

17. Removal (Burial, cremation, or removal. Which?) Date thereof: 8-23-46 (month) (day) (year)

Cemetery or crematory: Meadowridge, Dorsey, Maryland.

Location: Dorsey, Md.

18. Funeral director: W.W. Chambers

Address: 1400 Chapin St., N.W., Washington, D.C.

19. August 20, 1946 (Date rec'd by registrar) Mary Charlotte Smith Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 20 August 19 46 at 11:25 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 15 July 19 46, to 20 Aug. 19 46 and that I last saw him alive on 20 August 19 46

Immediate cause of death: Myelogenous Leukaemia — DURATION: Indef.

Due to:

Due to:

Other conditions:

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.:

Autopsy results: None

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: W. H. C. Smith, Comdr. M. D. or other
USNH Bethesda, Md.

Address: Date signed:

MARGIN RESERVED FOR BINDING. PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Give correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

8/29/46

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (76)

CERTIFICATE OF DEATH

08193

Reg. Diat. No. 223-

1. PLACE OF DEATH:

County Montgomery

City or town Takoma Park

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 13 days

Hospital, institution, or street address where death occurred:

Washington Sanitorium & Hospital

How long in hospital or institution? 13 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State District County

City or town Washington

(If outside city or town limits, write RURAL and give nearest town)

Street No. 218 U.S.T. N.E.

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Mrs. Florence E Neely

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed or divorced
Female	white	widow

6.(b) Name of husband or wife Harry M. Neely - deceased

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) December 25, 1892

8. AGE: Years	Months	Days	If less than one day
53	8	28	..... hrs. ..... min.

9. Birthplace Washington, D.C.
(Town, county, and state)

10. Usual occupation Bookkeeper

11. Industry or business

FATHER 12. Name Veenon Smith

13. Birthplace Washington D.C.

MOTHER 14. Maiden name Nettie Carter

15. Birthplace

16. Informant Sanitorium Records

Address

17. Removal (Burial, cremation, or removal. Which?) Date thereof May 23 1946 (month) (day) (year)

Cemetery or crematory

Location

18. Funeral director Hunteemann Funeral Home

Address 5732 Georgia Ave.

19. May 23 1946 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH August 22 1946 at 11:59 PM

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from August 21 1946 to August 22 1946

and that I last saw h.. alive on August 22 1946

Immediate cause of death	DURATION
Ruptured Cerebral Aneurysm, right middle cerebral artery	3 Weeks
Due to Cerebral arteriosclerosis	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Vasilios S. Lambros M.D.
M. D. or other

Address 1029 Vermont Ave. N.W. Date signed 8-23-46

VS A15 9-45-15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (141-C)

08194

CERTIFICATE OF DEATH

Reg. Dist. No. 216

1. PLACE OF DEATH:
County: Montgomery
City or town: Bethesda, Maryland
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 15 Minutes
Hospital, Institution, or street address where death occurred:
Suburban Hospital
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Montgomery
City or town: Bethesda, Maryland
(If outside city or town limits, write RURAL and give nearest town)
Street No. 4810 Battery La,
(If rural, give LOCATION)
2.(a) If veteran, name war: No

3.(a) FULL NAME: INFANT LINDA JEAN NEILSON

3.(b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Single

6.(b) Name of husband or wife:
6.(c) If alive, give age: years
7. Birth date of deceased (mo., day, yr.):

8. AGE: Years | Months | Days | If less than one day: hrs. 15 min.

9. Birthplace: Bethesda, Maryland (Town, county, and state)
10. Usual occupation: None
11. Industry or business:

FATHER
12. Name: Robert Carlisle Neilson
13. Birthplace: Washington, D. C.

MOTHER
14. Maiden name: Jennie Elizabeth Stine
15. Birthplace: Penn.

16. Informant: Robert C. Neilson
Address: 4810 Battery Lane, Bethesda, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 8/17/46 (month) (day) (year)
Cemetery or crematory: Congressional Cemetery
Location: Washington, D. C.
18. Funeral director: Wm Reuben Dunphrey
Address: Bethesda, Maryland

19. 8/17 1946 (Date rec'd by registrar) Wm E Jones Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 16 August 1946 at 11 55 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 11 40 pm 16 Aug 1946, to 11 55 pm 16 Aug 1946
and that I last saw h.e.r alive on Aug 16 1946

Immediate cause of death	DURATION
Respiratory failure	
Due to: Bilateral atelectasis	
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.
Autopsy results: Bilateral atelectasis
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: Eleazer Lentz M.D.
M. D. or other
Address: 3120 Wisc. Ave. Date signed: 8-17-46

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

08195

223

Reg. Dist. No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH:

County: Montgomery

City or town: Takoma Park

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 28 Days

Hospital, institution, or street address where death occurred: Washington Sanit Hospital

How long in hospital or institution? 28 Days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Md. County: Montgomery

City or town: Washington Grove

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME: John Joseph Nuttall

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Nora Ethel Nuttall

6.(c) If alive, give age: 48 years

7. Birth date of deceased (mo., day, yr.): Dec 16-1898

8. AGE: Years	Months	Days	If less than one day: hrs.	min.
47	8	3		

9. Birthplace: Northampton Mass (Town, county, and state)

10. Usual occupation: Engineer

11. Industry or business: Red Cross Recreation

FATHER — 12. Name: Joseph Nuttall

FATHER — 13. Birthplace: Manchester Eng

MOTHER — 14. Maiden name: Annie Robinson

MOTHER — 15. Birthplace: London Eng

16. Informant: Wife Mrs Nora Nuttall

Address: Washington Grove Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof 8/21/46 (month) (day) (year)

Cemetery or crematory: Forest Oak Cemetery

Location: Gaithersburg Md

18. Funeral director: R C Gaither

Address: Gaithersburg Md

19. Aug 21 1946 (Date rec'd by registrar) J W Dudley Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: August 19 1946 at 3:40 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 23 1946 to Aug 19 1946 and that I last saw him alive on August 19 1946

Immediate cause of death	DURATION
Carcinoma of Pancreas	6 mos ?
Due to	
Due to	
Other conditions Metastases to Liver	?

(Include pregnancy within 3 months of death)

Major findings of operation: Date of op.

Autopsy results: Confirm above

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: Robert A Hare M.D. M. D. or other

Address: Takoma Park, Md. Date signed 8/19/46

Evidence for addition of date of death & change of age of deceased is shown on

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (18)

CERTIFICATE OF DEATH

08195

Reg. Dist. No. 216

FILM No. 106 SEP 5 1946

1. PLACE OF DEATH:
County Montgomery
City or town Bethesda (Rural)
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 1 day
Hospital, Institution, or street address where death occurred:
U.S. NAVAL HOSPITAL, BETHESDA, MD.
How long in hospital or institution? 1 day

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State ..... County .....
City or town Washington, D.C.
(If outside city or town limits, write RURAL and give nearest town)
Street No. 2½ 14th St., SE., Wash., D.C.
(If rural, give LOCATION)
2.(a) If veteran, name war World War I.

3.(a) FULL NAME PATTON, Alfred Jackson VAP

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	Negro	Married

6.(b) Name of husband or wife Mrs. Bernice Patton
6.(c) If alive, give age 46 years

7. Birth date of deceased (mo., day, yr.) 10-26-97

8. AGE: Years	Months	Days	If less than one day
48 ~~49~~	9	~~11~~ 24	..... hrs. ..... min.

9. Birthplace Pa. (Town, county, and state)
10. Usual occupation Guard, Dept. of Agriculture.
11. Industry or business

FATHER
12. Name Noah Patton
13. Birthplace Pa.

MOTHER
14. Maiden name Isabelle Martin
15. Birthplace Pa.

16. Informant Mrs. Bernice Patton
Address 2½ 14th St., SE., Wash., D.C.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Aug. 23, 1946 (month) (day) (year)
Cemetery or crematory Arlington National
Location Arlington, Virginia.
18. Funeral director HALL Bros. M. L. Hall
Address 621 Florida Avenue, NW., Wash., 1, D.C.

19. ..... 19..... (Date rec'd by registrar) ..... Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH August 20, 19 46, at M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 19 Aug 19 46, to 20 Aug 19 46 and that I last saw h.w.m. alive on 20 aug 19 46

	DURATION
Immediate cause of death Carcinoma Stomach	6 mo
Due to Pyloric obstruction	1 mo
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations .....
Date of op. .....
Autopsy results Carcinoma Stomach
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide ..... Date of .....
Where did injury occur? ..... (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) .....
Means of injury ..... Injured at work?

23. SIGNATURE W. D. Simmons Lt Comdr MC USN (M. D. or other)
Address USNH Bethesda Md Date signed 8/22/46

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 55-2

08197

CERTIFICATE OF DEATH

Reg. Dist. No. 216

1. PLACE OF DEATH:
County: Montgomery
City or town: Bethesda
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 3 weeks
Hospital, institution, or street address where death occurred:
4601 West Virginia Ave.,
How long in hospital or institution? None

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Montgomery
City or town: Bethesda
(If outside city or town limits, write RURAL and give nearest town)
Street No. 4601 West Virginia Ave.,
(If rural, give LOCATION)
2.(a) If veteran, name war: None

3.(a) FULL NAME: HENRIETTA PAULINE POST

3.(b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Married

6.(b) Name of husband or wife: ~~XXX~~ George Warren Post
6.(c) If alive, give age: 68 years

7. Birth date of deceased (mo., day, yr.): November 4, 1879

8. AGE: Years	Months	Days	If less than one day
66 66	9	16	....hrs. ....min.

9. Birthplace: Iuka, Ill. (Town, county, and state)
10. Usual occupation: Housewife
11. Industry or business: Home

FATHER
12. Name: John Frederick Weber
13. Birthplace: St. Louis, Mo.

MOTHER
14. Maiden name: Margaret Hatmaker
15. Birthplace: St. Louis, Mo.

16. Informant: Mrs. Clara Clatterbuck (daughter)
Address: Bethesda, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Aug. 23, 1946 (month) (day) (year)
Cemetery or crematory: Ft. Lincoln Cemetery
Location: Washington, D.C.

18. Funeral director: Wm Reuben Pumphrey
Address: Bethesda 14, Maryland

19. 8/21 1946 (Date rec'd by registrar) Wm E Jones Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: August 20, 1946, at 6:15P. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from January 20 1946, to Aug. 20 1946
and that I last saw her alive on August 20th 1946

Immediate cause of death	DURATION
Respiratory Failure.	
Due to: Cancer of the Pelvis	
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations: ....Date of op. ....
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of ....
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: Frank Jaggers Jr. M.D. M. D. or other
Address: 8016 Old Georgetown Rd., Bethesda 14, Md. Date signed: 8/21/46

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 830

08198

CERTIFICATE OF DEATH

Reg. Dist. No. 218

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County: Montg Co,

City or town: Washington Grove. Md,
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 40yrs

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Montgomery

City or town: Washington Grove
(If outside city or town limits, write RURAL and give nearest town)

Street No.
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME: Alice Mary Rabbitt

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widow

6.(b) Name of husband or wife: Albert F Rabbitt

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Sept 21st 1857

8. AGE: Years	Months	Days	If less than one day
1857 88	10	29	hrs. min.

9. Birthplace: Maryland
(Town, county, and state)

10. Usual occupation: House Wife

11. Industry or business

FATHER — 12. Name: Charles Bready

13. Birthplace: Md

MOTHER — 14. Maiden name: Mary Jane Beall

15. Birthplace: Md

16. Informant: Miss Mary Rabbitt

Address: Washington Grove, Md,

17. Burial (Burial, cremation, or removal. Which?) Date thereof 8/14/46 (month) (day) (year)

Cemetery or crematory: Forest Oak Cemetery

Location: Gaithersburg Md,

18. Funeral director: Ernest C Gartner

Address: Gaithersburg Md,

19. Aug 12 1946 (Date rec'd by registrar) Edward L Cooke Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Aug 12 1946 at 1:00 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 28 1946, to Aug 12 1946

and that I last saw her alive on Aug 10 1946

Immediate cause of death	DURATION
Cerebral hemorrhage	20 days
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE: Frank J. Brochant M. D.
M. D. or other

Address: Gaithersburg Md Date signed 8-12-46

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 48-a

CERTIFICATE OF DEATH

08193

Reg. Dist. No. 212

1. PLACE OF DEATH:
County Montgomery
City or town Beallsville Md
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 4 Yrs
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Md County Montg
City or town Beallsville Md
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME Medora C. Rawlings ~~RAWLINGS~~

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	W	Married

6.(b) Name of husband or wife Robert E Rawlings
6.(c) If alive, give age 56 years

7. Birth date of deceased (mo., day, yr.) Sept. 24 - 1898

8. AGE:

Years	Months	Days	If less than one day
47	10	14	....hrs. ....min.

9. Birthplace Duluth - Minn. (Town, county, and state)
10. Usual occupation Housewife
11. Industry or business

FATHER
12. Name Simon Jeffery
13. Birthplace Mich

MOTHER
14. Maiden name Bessie Call
15. Birthplace Wisc.

16. Informant Robert E Rawlings
Address Beallsville, Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof Aug 10-46 (month) (day) (year)
Cemetery or crematory Monocacy
Location Beallsville Md

18. Funeral director William B. Hilton
Address Barnesville, Md

19. Aug 10 1946 (Date rec'd by registrar) Mrs. C.C. Hilton by Mr. W.B.H. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH August 8 1946 at 4 30 PM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 1 1946 to August 8 1946
and that I last saw her alive on August 5 1946

Immediate cause of death	DURATION
CARCINOMA OF UTERUS (CERVIX)	9 Months
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations CARCINOMA OF CERVIX with Extension To Pelvis Date of op. Feb 1946
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE Arthur K. John M. D. or other
Address Poolesville, Maryland Date signed Aug 9-1946

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (191-a)

CERTIFICATE OF DEATH

08200

Reg. Dist. No. 214

1. PLACE OF DEATH:
County: Montgomery
City or town: Burtonsville
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 7 years
Hospital, institution, or street address where death occurred:
Soper Rd., Burtonsville, Laurel RFD
How long in hospital or institution? None

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Montgomery
City or town: Burtonsville
(If outside city or town limits, write RURAL and give nearest town)
Street No. Soper RD, Burtonsville, Laurel
(If rural, give LOCATION) RFD #2
2.(a) If veteran, name war: None

3.(a) FULL NAME: FANNIE SYDONIA Ricketts

3.(b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widowed

6.(b) Name of husband or wife: S. Jackson Ricketts (deceased) 6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): August 13, 1865

8. AGE: Years	Months	Days	If less than one day
81	0	18	..... hrs. ..... min.

9. Birthplace: Glen, Montgomery Co., Md.
(Town, county, and state)

10. Usual occupation: Housewife

11. Industry or business: Home

FATHER
12. Name: James W. Selby
13. Birthplace: Montgomery Co., Maryland

MOTHER
14. Maiden name: Katherine Miller
15. Birthplace: Montgomery Co., Maryland

16. Informant: James W. Ricketts (son)
Address: Burtonsville, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof 9/2/46 (month) (day) (year)
Cemetery or Crematory: Rockville Union Cemetery
Location: Rockville, Maryland

18. Funeral director: Wm Reuben Thompson
Address: Rockville, Maryland

19. Sept 2 1946 Josephine M. Schaffer
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 8 31 1946 at 12 AM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 1 10 1945 to 8 31 1946
and that I last saw h[illegible] alive on 8 31 1946

	DURATION
Immediate cause of death: Acute Cardiac Dilitation	1 day
Due to: Hypertension & Arteriosclerosis	5 yrs
Due to: Diabetes Senilis	5 yrs
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....

Autopsy results: .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: ..... Date of .....
Where did injury occur? ..... (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) .....
Means of Injury ..... Injured at work?

23. SIGNATURE: B Robinson M. D. or other
Address: Laurel Md. Date signed 8 31 46

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-1

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (108)

08201

CERTIFICATE OF DEATH

Reg. Diat. No. 216

1. PLACE OF DEATH:

County: Montgomery

City or town: Bethesda, Md.
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? —

Hospital, Institution, or street address where death occurred:
Suburban Hospital

How long in hospital or institution? 3 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Montgomery

City or town: Silver Spring 5
(If outside city or town limits, write RURAL and give nearest town)

Street No. 1540 Live Oak Drive
(If rural, give LOCATION)

2.(a) If veteran, name war:

3. (a) FULL NAME: Russell, William E

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Ella M. Russell

6.(c) If alive, give age: ____ years

7. Birth date of deceased (mo., day, yr.): March 8 - 1886

8. AGE: Years	Months	Days	If less than one day
60	5	4	____ hrs. ____ min.

9. Birthplace: Washington Dist. of Columbia
(Town, county, and state)

10. Usual occupation: merchant

11. Industry or business

FATHER — 12. Name: John Russell

FATHER — 13. Birthplace: Nash. D.C.

MOTHER — 14. Maiden name: ? Johnston

MOTHER — 15. Birthplace

16. Informant: Daniel W Bowie

Address: 8201 Schuyler St Nash.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 8/15/46 (month) (day) (year)

Cemetery or crematory: Cedar Hill Cem.

Location: Md.

18. Funeral director: Joseph Gawler Sons.

Address: 1756 Pa. Ave. N.W. Wash. D.C.

19. 8/13 1946 Wm E Jobco
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: August 12 1946, at 8:20 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Aug. 5 1946 to Aug. 12 1946 and that I last saw h. l. M. alive on Aug. 12 1946

Immediate cause of death	DURATION
Cardiac failure	24 hrs
Due to: Lobar Pneumonia rt. Lung	3 days
Due to: Chronic Ulcerative tuberculosis respiratories	?
Other conditions: Healed tuberculosis left apex.	30 yrs.

(Include pregnancy within 3 months of death)

Major findings of operations: no operation Date of op. —

Autopsy results: Lobar pneumonia upper & lower rt. lung

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, Industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE: Frank G. Zack M.D.
M. D. or other

Address: 8248 Ga. Ave Silver Spring, Md. Date signed 8/13/46

VS A-15 9-45-15

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (MD)

CERTIFICATE OF DEATH

08202

Reg. Dist. No. 216

1. PLACE OF DEATH:
County: Montgomery
City or town: Bethesda (Rural)
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 1 mo. 9 days
Hospital, institution, or street address where death occurred:
U. S. Naval Hospital, Bethesda, Md.
How long in hospital or institution? 1 mo. 9 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: County:
City or town: Washington, D.C.
(If outside city or town limits, write RURAL and give nearest town)
Street No. 2924 Carlton Ave.NE., Wash.,D.C.
(If rural, give LOCATION)
2.(a) If veteran, name war: Retired Naval Officer.

3.(a) FULL NAME: SABELSTROM, Gustave (n), Lt. USN.,Ret. Inact.

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	W-US	Married

6.(b) Name of husband or wife: Mrs. Mathilda Sabelstrom
6.(c) If alive, give age: 70 years

7. Birth date of deceased (mo., day, yr.): 9 July 1866

8. AGE:

Years	Months	Days	If less than one day
80	1	3	....hrs. ....min.

9. Birthplace: Sweden
(Town, county, and state)

10. Usual occupation: Retired

11. Industry or business

FATHER
12. Name: Hans Sablestrom
13. Birthplace: Sweden

MOTHER
14. Maiden name: Emma Jeppson
15. Birthplace: Sweden

16. Informant: (Wife) Mrs. Mathilda Sabelstrom
Address: 2924 Carlton Ave.,NE, Wash.,D.C.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Aug. 14, 1946 (month) (day) (year)
Cemetery or crematory: Arlington National Cemetery
Location: Arlington, Va.

18. Funeral director: W. W. Chambers Co.
Address: 1400 Chapin St. N.W. Washington D.C.

19. ..... 19..... (Date rec'd by registrar) Marcy C. Smith Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 12 August 1946, at 3:14 a.m.

21. I CERTIFY that death occurred on the date above etated; that I attended deceased from 3 July 1946, to 12 August 1946
and that I last saw him alive on 12 August 1946

	DURATION
Immediate cause of death: Congestive heart failure	2 months
Due to: Valvular Heart Disease - Aortic Insufficiency	3 months
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: Paul T. Dickens Jr. (MC) USN Comdr
(M. D., or other)
Address: USNH, NNMC, Beth. Md. Date signed: 12 Aug. 1946

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

W. W. Chambers
1400 Chapin St. N.W.
Wash., D.C.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (462)

CERTIFICATE OF DEATH

08203

Reg. Dist. No. 223-

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15

1. PLACE OF DEATH:

County: Montgomery

City or town: Takoma Park, Maryland
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 15 days

Hospital, institution, or street address where death occurred:
Washington Sanitarium and Hospital

How long in hospital or institution? 15 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: D.C. County:

City or town: Washington
(If outside city or town limits, write RURAL and give nearest town)

Street No. 4602 Munson Avenue
(If rural, give LOCATION)

2.(a) If veteran, name war: ✓

3.(a) FULL NAME: Mrs. Sue Oral Shelton

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	Wh	Widowed

6.(b) Name of husband or wife: Mr. Jack Shelton (deceased)

6.(c) If alive, give age: ..... years

7. Birth date of deceased (mo., day, yr.): Sept. 28, 1893

8. AGE: Years	Months	Days	If less than one day
52	10	23	..... hrs. ..... min.

9. Birthplace: Dayton, Ohio
(Town, county, and state)

10. Usual occupation: Government Clerk

11. Industry or business:

FATHER
12. Name: Chester Linden Ballard
13. Birthplace: Indiana

MOTHER
14. Maiden name: Ida Mary Mussetter
15. Birthplace: Ohio

16. Informant: Washington Sanitarium Records
Address: Takoma Park

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Aug 23, 1946 (month) (day) (year)

Cemetery or crematory: Cedar Hill Cemetery

Location: Prince George's Co., Md.

18. Funeral director: S. H. Hines Co.

Address: 2901-14th St. N.W.

19. Aug-20 1946 (Date rec'd by registrar) J. Wilton Dodd Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Aug. 20 1946, at 9 56 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 29 1946, to 8-20-1946 and that I last saw her alive on 8-19-1946

	DURATION
Immediate cause of death: Cerebral hemorrhage & infarct rt fronto-parietal, Hemiplegia L.	One day
Due to: Resection right colon for carcinoma of cecum	One wk.
Due to: Hypertension & moderate arterio sclerosis, cerebral, coronary, aorta.	
Other conditions: Chronic passive Congestion with edema of kidneys & lungs.	

(Include pregnancy within 3 months of death)

Major findings of operation: Carcinoma of Cecum

Ileo-cecal resection Date of Op. 8-12-46

Autopsy results: As noted above

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE: Leonard E. Calvert M.D. M. D. or other

Address: 7894 Georgia Ave., Silver Spring Md. Date signed 8-20-46

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (157-R)

CERTIFICATE OF DEATH

7445 08204

Reg. Dist. No. 216

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

1. PLACE OF DEATH:

County: Montgomery

City or town: Bethesda

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred: Suburban Hospital

How long in hospital or institution? 24 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: County:

City or town: Washington D. C.

(If outside city or town limits, write RURAL and give nearest town)

Street No. 200-10th Street, S.E.

(If rural, give LOCATION)

2.(a) If veteran, name war:

3.(a) FULL NAME David S. Sizer

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	white	married

6.(b) Name of husband or wife: Sarah

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Sept. 9, 1912.

8. AGE: Years	Months	Days	If less than one day
33	11	15	hrs. min.

9. Birthplace: Pittsburgh, Pa. (Town, county, and state)

10. Usual occupation: Clerk

11. Industry or business

FATHER 12. Name	Clarence Sizer
FATHER 13. Birthplace	Pittsburgh, Pa.
MOTHER 14. Maiden name	Bessie Edison
MOTHER 15. Birthplace	? Virginia

16. Informant: Sarah Sizer

Address: 200-10th St. S.E.

17. Removal (Burial, cremation, or removal. Which?) Date thereof Aug 25, 1946 (month) (day) (year)

Cemetery or crematory:

Location: Washington, D. C.

18. Funeral director: Robert A. Mattingly

Address: 131-11th St. S.E. Washington D.C.

19. 8/25 1946 (Date rec'd by registrar) Wm. E. Jales Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Aug. 24, 1946 at 10:35 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Feb. 5 1942 to Aug. 24 1946 and that I last saw him alive on August 24 1946

Immediate cause of death	Polycystic Kidneys	DURATION: lifetime
Due to		
Due to		
Other conditions		

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: Katharine A. Chapman, M.D. M. D. or other

Address: 29 West Baltimore St. Kensington, Md. Date signed: 8/25/46

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (12)

CERTIFICATE OF DEATH

08205

Reg. Dist. No. 7-14

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County: Montgomery

City or town: Silver Spring

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

~~Usual residence~~ or street address where death occurred:

8605 Hawley Road

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Montgomery

City or town: Silver Spring

(If outside city or town limits, write RURAL and give nearest town)

Street No. 8605 Hawley Road

(If rural, give LOCATION)

2.(a) If veteran, name war: X

3. (a) FULL NAME: MARY JOAN SLATER

3. (b) Social Security Number: 212-24-2558

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
female	white	single

6.(b) Name of husband or wife: X

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Jan. 2nd. 1929

8. AGE: Years	Months	Days	If less than one day
17	7	9	hrs. min.

9. Birthplace: Washington, D. C. (Town, county, and state)

10. Usual occupation: none

11. Industry or business

FATHER

12. Name: George A. Slater

13. Birthplace: Washington, D. C.

MOTHER

14. Maiden name: Margaret Glenn

15. Birthplace: Staunton, Va.

16. Informant: Mrs. George A. Slater

Address: 8605 Hawley Rd. Silver Spring.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 8 - 16 - 1946 (month) (day) (year)

Cemetery or crematory: Mt. Olivet

Location: Washington, D. C.

18. Funeral director: Warner E. Pumphrey

Address: Silver Spring, Md.

19. Aug 16 1946 (Date rec'd by registrar) Josephine M. Schaeffer (Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH: August 11 1946, at 1:55 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from September 23 1941 to August 11 1946 and that I last saw h-e alive on Aug. 9 1946

Immediate cause of death	DURATION
(a) Status asthmaticus	20 min.
Due to (b) Asthma & atopic	10+ yrs.
Due to (c)	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: —

Date of op. —

Autopsy results: —

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: — Date of —

Where did injury occur? — (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) —

Means of injury — Injured at work? —

23. SIGNATURE: H. M. Schaeffer M. D.

M. D. or other

Address: Silver Spring Md. Date signed 8/11/46

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (13)

08206

CERTIFICATE OF DEATH

Reg. Diat. No. 211

1. PLACE OF DEATH:
County Montgomery
City or town Brownings ville Rural
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? Life Years
Hospital, Institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Montgomery
City or town Brownings ville Rural
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME Virginia R. Smith

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	W	Married

6.(b) Name of husband or wife Anthony Smith
6.(c) If alive, give age 70 years
7. Birth date of deceased (mo., day, yr.) Oct 2. 1873

8. AGE: Years	Months	Days	If less than one day
72	10	28	....hrs. ....min.

9. Birthplace Howard Co Md
(Town, county, and state)
10. Usual occupation Domestic
11. Industry or business Home
MOTHER FATHER
12. Name John R. Shipley
13. Birthplace Carroll Co Md
MOTHER
14. Maiden name Mary Ellen Snowden
15. Birthplace Carroll Co Md
16. Informant Anthony Smith
Address Brownings ville Md
17. Burial (Burial, cremation, or removal. Which?) Date thereof Sept 2. 1946 (month) (day) (year)
Cemetery or crematory Bethesda Md
Location Brownings ville Md
18. Funeral director Roy W. Barber
Address Laytonsville Md
19. ....19.... (Date rec'd by registrar) Della N. Burdette Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH August 30 1946, at 6:30 P.M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from December 16, 1941 to August 30, 1946
and that I last saw her alive on June 25, 1946.

	DURATION
Immediate cause of death Arteriosclerotic Cardio-vascular disease.	10 years.
Due to Chronic glomerular nephritis	6 years
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE James P. Kerr M.D.
M. D. or other
Address Damascus Md Date signed 9/2/46.

VS A15 9-45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (94a)

CERTIFICATE OF DEATH

* 082023 Reg. Dist. No. 23

1. PLACE OF DEATH:
County Montgomery
City or town Takoma Park
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 40 years
Hospital, institution, or street address where death occurred:
224 Holly Ave.
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Md. County Montgomery
City or town Takoma Park
(If outside city or town limits, write RURAL and give nearest town)
Street No. 224 Holly Ave.
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME Neville D. Staughton

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	W	MARRIED

8.(b) Name of husband or wife Lottie Denny Staughton
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) DEC. 16, 1870.

8. AGE:

Years	Months	Days	If less than one day
75	8	14	..... hrs. ..... min.

9. Birthplace WINNONA, (Town, county, and state) MINN

10. Usual occupation DOCTOR

11. Industry or business NATUROPATH - CHIROPRACTOR

FATHER 12. Name NEVILLE STAUGHTON
13. Birthplace CINCINNATI, OHIO.

MOTHER 14. Maiden name PLEIADES ELOISE DAYTON
15. Birthplace WHITE HALL, N.Y.

16. Informant MRS. CHARLOTTE GEARY
Address 8349 COLESVILLE Rd, Sil. Spg. Md.

17. BURIAL (Burial, cremation, or removal. Which?) Date thereof SEPT. 1 1946. (month) (day) (year)
Cemetery or crematory George Washington Memorial Cem.
Location Prince Georges County, Maryland

18. Funeral director Arthur Walters
Address 254 Carroll St., Takoma Park, D.C.

19. Aug 30 19 46 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug 30 19 46, at 4:00 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dep. Med. Exam Case 19 ..... to ..... 19 .....
and that I last saw h..... alive on ..... 19 .....

Immediate cause of death ..... DURATION
Coronary occlusion — Immed. death
Due to .....
Due to .....
Other conditions .....
(Include pregnancy within 3 months of death)

Major findings of operations .....
Date of op. .....
Autopsy results .....
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide ..... Date of .....
Where did injury occur? ..... (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) .....
Means of injury ..... Injured at work?

23. SIGNATURE Frank J. Brozhart M.D.
M. D. or other
Address Dep. Med. Exam. Date signed 8-30-46.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 756

CERTIFICATE OF DEATH

Reg. Dist. No. 08208 223

1. PLACE OF DEATH:
County: Montgomery
City or town: Takoma Park.
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, Institution, or street address where death occurred: Wash. San. + Sturb, Takoma Park, Md
How long in hospital or institution? 18 hrs

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md County: Montgomery
City or town: Takoma Park
(If outside city or town limits, write RURAL and give nearest town)
Street No.: 19 Boyd.
(If rural, give LOCATION)
2.(a) If veteran, name war: No

3.(a) FULL NAME: Albert Michael Thomas.

3.(b) Social Security Number: 215-14-7154.

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	divorced

6.(b) Name of ~~husband or~~ wife: Esther L Hurley
6.(c) If alive, give age: ..... years

7. Birth date of deceased (mo., day, yr.): July 27 1888

8. AGE: Years: 58 | Months: 0 | Days: 8 | If less than one day: ..... hrs. ..... min.

9. Birthplace: Wash D.C.
(Town, county, and state)

10. Usual occupation: POLICEMAN.

11. Industry or business: Montg Co. Police Dept

FATHER
12. Name: JAMES E THOMAS.
13. Birthplace: WASHINGTON - D.C.

MOTHER
14. Maiden name: KATIE E KELLY
15. Birthplace: WASHINGTON - D.C.

16. Informant: MRS. FRANCIS M. FOWLER (SISTER)
Address: 19 BOYD AVE TAKOMA PARK.

17. BURIAL (Burial, cremation, or removal. Which?) Date thereof: AUG - 7 - 1946 (month) (day) (year)
Cemetery or Crematory: ST JOHNS.
Location: FOREST GLEN - MONTG. CO. MD

18. Funeral director: Warren E Pumphrey
Address: SILVER SPRING

19. Aug 6 1946 (Date rec'd by registrar) [signature] Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Aug 5 1946 at 5 25 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan 30 1938, to Aug 5 1946 and that I last saw h.. alive on Aug 4 1946

	DURATION
Immediate cause of death: Acute Nephritis & Uremia.	2 days
Due to: Rheum. Heart	8 yrs.
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....

Autopsy results: .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: ..... Date of .....
Where did injury occur? ..... (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) .....
Means of injury ..... Injured at work?

23. SIGNATURE: Howard I Young M.D. or other
Address: 28 Carroll Ave Takoma Park Md Date signed: 8/5/46

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 2-12

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County: Montgomery

City or town: Rural - Poolesville
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 2 yrs

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Md County: Montgomery

City or town: Rural
(If outside city or town limits, write RURAL and give nearest town)

Street No.
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (d) FULL NAME: Hubert Hanes Trussell

3. (b) Social Security Number: None.

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	white	widowed

6.(b) Name of husband or wife: Fannie Trussell

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Oct. 18th. 1863

8. AGE: Years	Months	Days	If less than one day
83			hrs. min.

9. Birthplace: Clark County, Va.
(Town, county, and state)

10. Usual occupation: Farming

11. Industry or business

FATHER
12. Name: Unobtainable
13. Birthplace: "

MOTHER
14. Maiden name: Unobtainable
15. Birthplace: "

16. Informant: W. H. Trussell

Address: Dickerson, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Sept. 2-1946 (month) (day) (year)

Cemetery or crematory: Union Cemetery

Location: Leesburg, Va.

18. Funeral director: William B. Hilton

Address: Barnesville, Maryland

19. Aug. 31 1946 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Aug 31st 1946 at 1:10 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 10 1946 to Aug 31 1946 and that I last saw h alive on August 30 1946

Immediate cause of death: Carcinoma of Pancreas — DURATION: 3 Months

Due to:

Due to:

Other conditions: Prostate - hypertrophy — DURATION: years

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: Asher K. Tolson, M.D.
M. D. or other

Address: Poolesville, Md. Date signed: Aug 31, 1946

Evidence for the change of date of birth is shown on G1 08 12/17/46

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (64)

CERTIFICATE OF DEATH

08210

Reg. Dist. No. 223

1. PLACE OF DEATH:
County - Montgomery
City or town Takoma Park md
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 15 min
Hospital, Institution, or street address where death occurred:
Washington Sanitarium & Hosp
How long in hospital or institution? 15 min

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Montgomery
City or town Silver Spring
(If outside city or town limits, write RURAL and give nearest town)
Street No. 607 Sligo Ave
(If rural, give LOCATION)
2.(a) If veteran, name war WORLD WAR I.

3.(a) FULL NAME Robert L. Tyler

3.(b) Social Security Number 214-03-9361.

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of ~~husband or~~ wife MARIAN SCHRIDER
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) SEP- 30TH 1896.

8. AGE: Years	Months	Days	If less than one day
49	10	11	..... hrs. ..... min.

9. Birthplace MARYLAND (Town, county, and state)
10. Usual occupation PLUMBER.
11. Industry or business
FATHER 12. Name NOBLE S TYLER.
13. Birthplace MARYLAND.
MOTHER 14. Maiden name MARY JANE GLADMAN.
15. Birthplace MARYLAND
16. Informant MRS MARIAN S TYLER.
Address 607 SLIGO AVE - SILVER SPRING.
17. BURIAL (Burial, cremation, or removal. Which?) Date thereof AUG. 14 1946 (month) (day) (year)
Cemetery ~~or crematory~~ ST JOHNS.
Location FOREST GLEN. MONTG CO. MD
18. Funeral director Warner E Pumphrey -
Address SILVER SPRING - MD
19. Aug 13 1946 (Date rec'd by registrar) J. Wm. Doll Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug 11 1946 at 11:59 P.M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from
Dep. med. Exam. 19 ..... to ..... 19 .....
and that I last saw h..... alive on ..... 19 .....

Immediate cause of death	DURATION
Hemorrhage	
Due to gun shot wound in	
Rt. temple	45 min.
Due to (Suicide)	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations .....
Date of op. .....
Autopsy results .....
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Suicide Date of 8-11-46
Where did injury occur? Silver Spring (City or town) Monty (County) MD (State)
Injured at home, farm, industry, public place (where?) home
Means of injury gun shot Injured at work? NO

23. SIGNATURE Frank J. Brunett M.D. M. D. or other
Address Gaithersburg md Date signed 8-12-46

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (31-C)

CERTIFICATE OF DEATH

11821

Reg. Dist. No. 214

1. PLACE OF DEATH:

County: Montgomery

City or town: Silver Spring
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

~~Hospital or Institution~~ Street address where death occurred:
602 Gist Ave.

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Montgomery

City or town: Silver Spring
(If outside city or town limits, write RURAL and give nearest town)

Street No.: 602 Gist. Ave.
(If rural, give LOCATION)

2.(a) If veteran, name war: no

3.(a) FULL NAME: Estelle Mae Upton

3.(b) Social Security Number: none

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
female	white	married

6.(b) Name of husband or wife: Ernest F.

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): Oct. 28th. 1892

8. AGE: Years	Months	Days	If less than one day
53	19	27	..... hrs. ..... min.

9. Birthplace: Kentucky
(Town, county, and state)

10. Usual occupation: Housewife

11. Industry or business

FATHER
12. Name: James Dawson
13. Birthplace: Kentucky

MOTHER
14. Maiden name: Mahalia F. Traylor
15. Birthplace: Kentucky

16. Informant: Mr. Ernest F. Upton
Address: 602 Gist Ave. Silver Spring

17. Burial (Burial, cremation, or removal. Which?) Date thereof: 8-28-1946 (month) (day) (year)

Cemetery or ~~Crematory~~: Colesville M. E. Church

Location: Colesville, Montg. Co. Md.

18. Funeral director: Warner E. Pumphrey

Address: Silver Spring, Md.

19 Aug 27 1946 (Date rec'd by registrar) Josephine M. Schaeffer Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Aug 25 1946, at 0:30 P. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from
Dep. Med. Exam Case 19 ..... to ..... 19 .....
and that I last saw h..... alive on ..... 19 .....

Immediate cause of death	DURATION
Acute cardiac dilatation	due suddenly
Due to: Chronic Nephritis	1 yr.
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....

Autopsy results: .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE: Frank J. Bronchart M.D. Dep. Med. Exam. M. D. or other

Address: Gaithersburg md Date signed 8-28-46

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (130)

08212

CERTIFICATE OF DEATH

Reg. Dist. No. 216

1. PLACE OF DEATH:

County: Montgomery

City or town: Bethesda (rural)
(If ontside city or town limits, write RURAL and give nearest town)

How long in above place of death? 15 days

Hospital, Institution, or street address where death occurred:
U.S. Naval Hospital, Bethesda, Md.

How long in hospital or institution? 15 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: West Virginia County:

City or town:
(If outside city or town limits, write RURAL and give nearest town)

Street No.
(If rural, give LOCATION)

2.(a) If veteran, name war:

3. (a) FULL NAME

WELLS, Boots (n) Dependent

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Married

6.(b) Name of husband or wife: James Edward Wells

6.(c) If alive, give age: 24 years

7. Birth date of deceased (mo., day, yr.): 12 November 1924

8. AGE: Years	Months	Days	If less than one day
21	9	10	hrs. min.

9. Birthplace: West Virginia
(Town, county, and state)

10. Usual occupation: Housewife

11. Industry or business

FATHER
12. Name: JessieFrancis
13. Birthplace: Ky.

MOTHER
14. Maiden name: Mona Lambert West
15. Birthplace: Virginia

16. Informant: Husband: James Edward Wells
Address: USNAS, Armanent Test, Patuxent River, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Aug. 14, 1946 (month) (day) (year)

Cemetery or crematory: Lawson

Location: Stollings, W. Va.

18. Funeral director: W. W. Chambers Co.

Address: 1400 Champin St., NW, Wash., D.C.

19. 12 August 19 46 (Date rec'd by registrar) Mary Charlotte Smith Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 12 August 1946 19 ..., at 1550 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 7/28 19 46, to 8/12 19 46

and that I last saw h.. alive on 8/12 19 46

Immediate cause of death	DURATION
Acute Glomerulonephritis	2 weeks
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE: R S Barnes MD
M. D. or other

Address: USN Hosp. Bethesda, Md. Date signed: 11 Aug '46.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

Evidence for change of age of deceased is shown on

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (46)

CERTIFICATE OF DEATH

Reg. Dist. No. 0821 216

FILM No. 107 SEP 16 1946

1. PLACE OF DEATH:

County: Montgomery

City or town: Bethesda (Rural)
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 1 month (30 days)

Hospital, institution, or street address where death occurred:
U.S. Naval Hospital, Bethesda, Md.

How long in hospital or institution? 1 month.

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: County:

City or town: Washington, D.C.
(If outside city or town limits, write RURAL and give nesrest town)

Street No. 417 3rd St., NW., Wash., D.C.
(If rural, give LOCATION)

2.(a) If veteran, name war: World War I.

3.(a) FULL NAME

WILDAY, John Samson VAP

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	Negro	Single

6.(b) Name of husband or wife:

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): 7-4-90

8. AGE: Years	Months	Days	If less than one day
56 ~~55~~	1	18	hrs. min.

9. Birthplace: Virginia
(Town, county, and state)

10. Usual occupation: Veteran

11. Industry or business

FATHER
12. Name: Unknown
13. Birthplace: unknown

MOTHER
14. Maiden name: Adda Muse
15. Birthplace: Virginia

16. Informant: Sister: Mary Dyson
Address: 417 3rd St, NW, Wash., D.C.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: 8-26-46 (month) (day) (year)

Cemetery or crematory: Arlington National

Location: Arlington, Virginia

18. Funeral director: George Gardner
Address: 322 D St, SW, Wash., D.C. E Gardner

19. August 27, 1946 (Date rec'd by registrar) Mary Charlotte Smith Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 8-22-46 1946 at 4:30 P.M.

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from 7-22 1946 to 8-22 1946

and that I last saw him alive on 8-22-46 1946

	DURATION
Immediate cause of death: Carcinoma of Stomach	6 months
Due to:	
Due to:	
Other conditions: Hypertrophy of Prostate	

(Include pregnancy within 3 months of death)

Major findings of operations: Inoperable Ca of Stomach. Resection not performed. Biopsy revealed Ca of Stomach. Date of op. 8-10-46

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: Ronald Grant Comdr MC USN
M. D. or other

Address: USN Hospital Bethesda Md. Date signed: 8-24-46

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

8/29/46

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (93-2)

CERTIFICATE OF DEATH

★ 108214

Reg. Diat. No. 21X

1. PLACE OF DEATH:

County: Montgomery

City or town: Silver Spring
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:
957 Bonifant

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Montgomery

City or town: Silver Spring
(If outside city or town limits, write RURAL and give nearest town)

Street No.: 957 Bonifant St.
(If rural, give LOCATION)

2.(a) If veteran, name war: World War 1

3.(a) FULL NAME: GARLAND W WOLFE

3.(b) Social Security Number: 213-18-6903

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	white	married

6.(b) Name of husband or wife: Edith Lucille

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): March 3rd. 1892

8. AGE: Years	Months	Days	If less than one day
54	5	2	..... hrs. ..... min.

9. Birthplace: Virginia
(Town, county, and state)

10. Usual occupation: Retired

11. Industry or business: Automobile Dealer

FATHER
12. Name: William Wolfe
13. Birthplace: Virginia

MOTHER
14. Maiden name: Anna Hobbs
15. Birthplace: Virginia

16. Informant: Mrs. Edith L. Wolfe

Address: 957 Bonifant St.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Aug. 7th. 1946 (month) (day) (year)

Cemetery or crematory: Colesville M. E. Church

Location: Colesville, Montg. Co. Md.

16. Funeral director: Maine E Pumphrey

Address: Silver Spring

19. Aug 7 1946 (Date rec'd by registrar) Josephine M Schaeffer Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: August 5 1946, at 8:30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from January 1940 19..., to August 5 1946

and that I last saw h... alive on August 5 1946

	DURATION
Immediate cause of death: Acute Dilatation of Heart	3 mins
Due to: Generalized arteriosclerosis	30 years
Due to: Congestive Heart failure terminal	
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations: —

Date of op.

Autopsy results: —

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: — Date of —

Where did injury occur? — (City or town) — (County) — (State)

Injured at home, farm, industry, public place (where?) —

Means of injury — Injured at work?

23. SIGNATURE: W B Waddell M.D. M. D. or other

Address: 943 Bonifant St. Silver Spring Md. Date signed: 8/6/46

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (31-E)

08215

CERTIFICATE OF DEATH

Reg. Dist. No. 216

1. PLACE OF DEATH:
County: Montgomery
City or town: Bethesda (rural)
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
U.S. Naval Hospital, Bethesda, Md.
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: County:
City or town: Washington, D.C.
(If outside city or town limits, write RURAL and give nearest town)
Street No. 2213 S. St. N.E. Wash., D.C.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME: William Edelin WOOD

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	W-US	married

6.(b) Name of husband or wife: Anna Dorothy Wood
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): 7 August 1878

8. AGE: Years	Months	Days	If less than one day
67	11	29	hrs. min.

9. Birthplace: Washington, D.C. (Town, county, and state)
10. Usual occupation: veteran
11. Industry or business
FATHER 12. Name: Charles Wood
FATHER 13. Birthplace: Wash., D.C.
MOTHER 14. Maiden name: Catherine Edelin
MOTHER 15. Birthplace: Wash., D. C.
16. Informant: Mrs. W.E. Wood
Address: 2213 S St. N.E. Wash., D.C.
17. burial (Burial, cremation, or removal. Which?) Date thereof: 8-9-46 (month) (day) (year)
Cemetery or crematory: Arlington National
Location: Arlington, Va.
18. Funeral director: W. W. Chambers (Paone)
Address: 517 11th St., S.E., Wash., D.C.
19. 6 August 1946 (Date rec'd by registrar) Mary Charlotte Smith Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 6 August 1946, at 6:49a M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 8-2 1946, to 8-6 1946 and that I last saw him alive on 8-6 1946

Immediate cause of death	DURATION
uremia	4 wks
Due to: chronic glomerular nephritis	years
Due to:	
Other conditions: coronary artery sclerosis and chronic cholecystitis	

(Include pregnancy within 3 months of death)

Major findings of operation: Date of op.
Autopsy results: as above.
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: C W Thompson
C.W. THOMPSON Lt. Cdr (MC) USN (or other)
Address: NavHosp Bethesda, Md. Date signed

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 3-45-15M

8/9/46

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (16-a)

08216

CERTIFICATE OF DEATH

Reg. Dist. No. 218

1. PLACE OF DEATH:
County: Montg. Co,
City or town: Gaithersburg. Md,
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 1 Yr 4 Mo
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Montgomery
City or town: Gaithersburg Md.
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME: Laura Virginia Wright

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Single

6.(b) Name of husband or wife
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): Sept 9th 1858

8. AGE: Years	Months	Days	If less than one day
1858 87	9	2	..... hrs. ..... min.

9. Birthplace: Md,
(Town, county, and state)
10. Usual occupation: Missionary
11. Industry or business: "

FATHER
12. Name: Levin Wright
13. Birthplace: Md,

MOTHER
14. Maiden name: Helen F, Rose
15. Birthplace: Conn,

16. Informant: Methodist Home, H M Wilson
Address: Gaithersburg Md,

17. Burial (Burial, cremation, or removal. Which?) Date thereof 8/13th/46 (month) (day) (year)
Cemetery or crematory: Druid Ridge Cemetery
Location: Pikesville, Md,

18. Funeral director: Ernest C Gartner
Address: Gaithersburg. Md,

19. Aug. 12 1946 (Date rec'd by registrar) Edward L Cooke Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Aug - 11 - 1946 at 6 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Aug - 1945, to Aug - 11 - 1946 and that I last saw h.. alive on Aug - 1 - 1946

Immediate cause of death	DURATION
Senility	5-10 years
Due to: Senile Dementia	5 years
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide ..... Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE: William C Miller M.D.
M. D. or other
Address: Gaithersburg, Md. Date signed 8/11/46

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (32)

08217

CERTIFICATE OF DEATH

Reg. Dist. No. 223

1. PLACE OF DEATH:
County: Montgomery
City or town: Takoma Park
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 3 months, 9 days
Hospital, institution, or street address where death occurred:
506 Carroll Avenue
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: New York County: Oneida
City or town: Camden (Rural - route 3)
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war: ✓

3.(a) FULL NAME: Mertie Moriah Wright

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Married

6.(b) Name of husband or wife: Horatio Newell Wright
6.(c) If alive, give age: 78 years
7. Birth date of deceased (mo., day, yr.): August 1, 1866

8. AGE:

Years	Months	Days	If less than one day
80	0	8	hrs. min.

9. Birthplace: Camden, New York (Town, county, and state)
10. Usual occupation: House wife
11. Industry or business: Home
FATHER 12. Name: George Gerry Perry
13. Birthplace: Rome, N.Y.
MOTHER 14. Maiden name: Frances L. Perry
15. Birthplace: Rome, N.Y.
16. Informant: Mrs. Myrtle Stevens
Address: Durhamville, N.Y. Rt. #1.
17. Burial (Burial, cremation, or removal. Which?) Date thereof: August 12 1946. (month) (day) (year)
Cemetery or crematory:
Location: Camden, Oneida Co., N.Y.
18. Funeral director: J. Arthur Mallory
Address: 264 Carroll Ave. Takoma Park, D.C.
19. Aug 6 1946 (Date rec'd by registrar) J. Wm. Roth Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: August 9, 1946, at 2:35 P.M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 27 1946, to Aug. 9, 1946
and that I last saw h.e.r alive on August 9, 1946

	DURATION
Immediate cause of death: Myocarditis, chronic	Months
Due to: Arteriosclerosis and Hypertension	5½ yrs or longer
Due to:	
Other conditions: Arthritis, right jaw	4 months

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: Wallace H. Mook M.D. M. D. or other
Address: Takoma Park Md. Date signed: 8-9-46

VS A15 9-45-15

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.